Advanced Practice Mental Health and Wellness

Phone: 843-945-1452 Fax: 843-945-1489 Email:info@apmhofsc.com

Locations:

Myrtle Beach	Loris	Florence	Georgetown
630 Chestnut Road	3997 Meeting Street	2141 B Hoffmeyer Rd	1837 N Fraser Street
Myrtle Beach, SC 29572	Loris, SC 29569	Florence, SC 29501	Georgetown, SC 29440

PATIENT "NO SHOW" POLICY

"No Show" Definition: The occurrence in which a patient fails to notify a staff member at Advanced Practice Mental Health and Wellness of South Carolina within 24 hours of his/her scheduled appointment to cancel or reschedule his/her appointment or does attend scheduled appointment be it telehealth or in person within the given grace period. Nonpayment for telehealth before 10am on the appointment day will be considered a no show.

Policy Terms & Conditions: Advanced Practice Mental Health and Wellness allows 2 "no shows" within a (rolling) one year time frame. On the 3rd occurrence, we proceed with termination of the physician patient relationship for a 3-year term. Upon termination, our office will continue to direct care for a termed patient for any emergent medical issues and may refill any medical necessary medications within 30 days from the date of termination. Within that 30- day time period, the termed patient must proceed with securing a new physician.

Reason for Policy: "No show" occurrences severely impact our practice financially, and it does not allow us the opportunity to schedule another patient in your absence. We, in addition to all other medical practices, request at least a 24-hour notice of cancellation when a patient is unable to attend his/her scheduled appointment.

I, _____, have received the Patient "No Show" Policy and agree to the terms and conditions set forth in this policy. I promise to provide at least a 24-hour notice to
an Advanced Practice Mental Health and Wellness staff member when I am unable to attend a
scheduled appointment or pay copay for telehealth. If I fail to comply, upon my 2nd "no show" occurrence, I understand that I will be terminated from the practice for a 3-year term.

Name: _____Signature: _____

Date: _____