Cancellation Policy Contract

This Cancellation Policy Contract is entered into between Comprehensive Neurology Center and the undersigned patient _____as of the date of signature. By signing this Contract, the Patient agrees to adhere to the terms and conditions outlined herein regarding appointment cancellations and no-shows.

1. Appointment Cancellation:

- The Patient agrees to provide at least **24 hours' notice** for the cancellation or rescheduling of any appointment. This notice must be given by calling our office at **(469) 977-1010** or by emailing **scheduling@compneurocenter.com**.

2. Late Cancellations:

- Appointments canceled or rescheduled with less than **24 hours' notice** will incur a cancellation fee of **$50** for follow-up appointments**, $100** for new patient appointments and **$150** for procedures or testing appointments.
- This fee compensates for the reserved time that could have been allocated to another patient.

3. No-Shows:

- Patients who do not show up for their scheduled appointment without prior notice will be charged the same amount as late cancellations. Repeated no-shows may result in the patient being terminated from the practice.

4. Exceptions:

- The Clinic acknowledges that emergencies and exceptional circumstances may arise. In such cases, the Patient should contact the Clinic as soon as possible. The Clinic will review these circumstances and may, at its discretion, waive the cancellation fee.

5. Responsibility:

- The Patient is responsible for tracking their own appointment dates and times. The Clinic will not be held liable for missed appointments due to patient oversight. We recommend setting personal reminders to ensure timely attendance.

6. Payment Terms:

- All cancellation and no-show fees must be settled within **7-10 business** days of the invoice date. Failure to pay these fees may result in the suspension of future appointments or other administrative actions.

7. Acknowledgment and Agreement:

- By signing below, the Patient acknowledges that they have read, understood, and agreed to the terms of this Cancellation Policy Contract. This agreement is binding and will be enforced for all future appointments.

Signature: _____ Date: _____

Clinic Representative: _____ Date: _____

1600 Coit Road, Suite 406, Plano, TX 75075 **Phone# 469-977-1010** **Fax#469-977-1155**

www.compneurocenter.com **scheduling@compneurocenter.com**