First Medical Care

No-show Policy Form

This practice reserves the right to charge a $25 no show fee to patients who fail to keep their appointments, or do not cancel their appointments, without notifying the practice.

We ask that all patients please give us 24 hours' notice of cancellation.

To ensure we do the best job possible keeping you informed about your appointments in a timely manner, we request that you frequently check your contact information we have in our files.

I, (please print) _____, have read and understand the No Show Policy and do agree that if I do not cancel my appointment 24 hours prior to my appointment, or if I do not attend my appointment, I will be charged the $25 fee.

Patient signature: _____
Date: _____

2536 Lawrenceville Highway, Decatur, GA 30033 ● (770) 934-6832 ● FAX (770) 934-6337 ● info@FirstMedicalCare.com ● FirstMedicalCareInc.com