

SIBTE A. KAZMI, M.D.  
814 Toll House Avenue  
Frederick, MD 21701  
(301) 662-8310

Practice Of  
Internal Medicine  
&  
General Practice

### **MISSED APPOINTMENT POLICY**

We are glad you have chosen us to provide your medical care. If you miss your appointments, you compromise your care. Annual office visits are required for continuity of care and necessary evaluations of your medical care. Medical services will be held if you fail to schedule your annual visit. We want to remind you of our office policies regarding missed appointments.

A missed appointment is when you fail to show up for an appointment without a phone call or cancel without prior notification.

We strive to be on time for your scheduled appointment and ask that you give us the courtesy of a call when you are unable to keep your appointment. We have outlined our missed appoint policies below.

### **ROUTINE OFFICE VISITS**

We require 24 hour notice for all Routine office visits otherwise a \$40.00 missed appointment fee will be charged.

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|---|--|
| 1 <sup>st</sup> missed appointment:                     | We will call to reschedule your appointment. You may be charged a missed appointment fee of \$40.00. |
| 2 <sup>nd</sup> and 3 <sup>rd</sup> missed appointment: | You will receive a letter regarding your missed appointment and a fee of \$40.00.                    |
| 4 <sup>th</sup> missed appointment                      | You will be charged \$40.00 and you will receive a discharge letter from our practice.               |

### **NEW PATIENT, PHYSICALS AND PRE OP PHYSICALS**

We require 72 hour notice for ALL New Patient, Yearly Physicals, and Pre Op Physicals otherwise a \$75.00 missed appointment fee will be charged.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments, deductibles, and missed appointment fees are my responsibility.

I authorize my insurance benefits be paid directly to (Sibte A. Kazmi MD LLC).

I authorize (Sibte A. Kazmi MD LLC) to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name