Naugatuck Valley ent Ear, Nose & Throat Associates LLC

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Naugatuck Valley ENT Associates. When you schedule an appointment with NVENTA, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours before your appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

Effective January 1, 2021, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered A No Show and charged a $35.00 fee.

Any established patient who fails to show or cancels/reschedules an appointment with no 24-hour notice a second time will be charged a $50.00 fee.

If a third No Show or cancellation/reschedule with no 24-hour notice should occur, the patient may be dismissed as a patient from Naugatuck Valley Ear Nose and Throat Associates.

Any new patient who fails to show up for their initial visit will not be rescheduled.

The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

As a courtesy, we make reminder calls for appointments.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Practice Administrator. You may contact NVENTA 24 hours a day, 7 days a week, at the number below. Should it be after regular business hours Monday through Friday or during a weekend, you may leave a message. Messages left on our voicemail are acceptable.

Naugatuck Valley Ear Nose and Throat Associates 203-578-4630

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

(Parent/Legal Guardian) Relationship to Patient Signature

_____ _____

Printed Name Date