Office Appointment Cancellation Policy

University of Virginia Plastic Surgery
Jeremy A. Benedetti, M.D. |Plastic and Reconstructive Surgery

Dear Patient,

Thank you for trusting your medical care to University of Virginia Plastic Surgery. We strive to render excellent medical care to you and all of our patients. In order to be consistent with this philosophy, University of Virginia Plastic Surgery uses an appointment system that sets aside ample time for a patient dependent on the patient's current needs.

If you do not show up for your scheduled appointment, or notify us of your inability to keep you appointment by phone at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. With that in mind, an Office Appointment Cancellation Policy has been implemented .The policy is for ALL types of visits including physician visit, nurse visits and medical aesthetician visits.

Our policy is as follows:

1. We request 24 hour notification by phone in the event that you need to reschedule or cancel your appointment. This will make the appointment time available to someone else. Our scheduling number is 434-924-1234.
2. If you miss an appointment and do not contact us with at least 24 hours prior notice, we will consider this to be a missed appointment and you will be charged a $100 fee.
3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length. If you are more than 15 minutes late to your scheduled appointment time, we may need to reschedule this appointment.
4. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive your reminder phone call or message, the cancelation policy remains in effect.

If you have any questions regarding this policy, please contact our office staff at 434-924-1234 and we will be glad to clarify any questions you may have.

I have read and understand the Medical Appointment Cancellation Policy and agree to be bound by its terms.

_____ _____

Signature (Patient / Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

Payment Method

_____ _____ _____

Credit Card Type Card Number Security Code

_____/_____

Expiration date MM/YYYY

Billing Information

_____

Address

_____ _____ _____

City State Zipcode