NJ Advanced Surgical Solutions/JSWCC

222 Schanck Rd., Suite 200
Freehold, NJ 0778
800-920-9928

LATE TO APPOINTMENT POLICY

If you are an established patient and you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible. Likewise, if you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 15 minutes to complete the forms and the registration process, you may also be asked to reschedule. We ask that you please be courteous of your provider's valuable time and attention. The physicians, office staff, as well as your fellow patients will thank you.

MISSED APPOINTMENT OR "NO-SHOW" POLICY

While we make every effort to provide a reminder call/text/email at least 24 hours before your appointment, it is your responsibility to remember your appointment. We charge a $25 missed appointment fee to patients who do not keep their scheduled appointment time or who cancel less than 24 hours in advance. If this should happen more than twice, a $50 charge will be incurred for the third incident. After three (3) missed appointments, the practice may at its discretion choose to discontinue your care.

All fees must be paid before a new appointment can be scheduled.

I _____ agree to allow NJ Advanced Surgical Solutions/JSWCC to charge my credit card below for agreed upon cancellation policy fee; $25 when appropriate. I understand that my information will be saved to file for future transactions on my account.

Type of card: _____

Card #: _____

Exp Date: _____

CVV: _____ **Zip Code:** _____

_____ _____

Name of Patient **Signature of Patient**

_____

Date