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# No - Show Penalty
# and Incidentals Form

*Failure to cancel any checked appointments 72 hours in advance will result in the following penalties. You are responsible for the incidentals. You will be contacted by phone, text, or e-mail.*

1) A scheduled sleep office consult will result in a $85 no-show penalty fee.
2) A scheduled home sleep study pick up and next day return sleep study equipment will result in a $180 penalty fee.
3) A scheduled in Sleep laboratory sleep study will result in a $300 no-show penalty fee.

A) Patient's Name, Last______________, First__________________, Middle: _________________

B) Patient's Legal Guardian Name, Last_______________, First _____________. Middle__________

C) Patient's Address______________________________________________________________

D) Patient's Phone Number:_______________________Patient's Email: ____________________________

E) No show fee,

1) No show sleep office consult penalty fee, $85.00

2) Failure to cancel scheduled home sleep study pick up and next day return sleep study equipment penalty fee, $180.00.

3) Failure to cancel scheduled in Sleep laboratory sleep study, penalty fee, $300.00.

4) Incidental's fee, $1000.00

5) <u>Method of Payment:</u>

1) -------- Check,

2) ___ Credit card number _______________ exp date _____ three-digit security code ____ zip code ______
* **Note:** American Express credit card not accepted.

F) For security reasons do not send this form with credit card information via email. Submit this form in person, via fax or mail.

G) By signing and submitting this form, I (patient/ patient's legal guardian) ______________________ understand that I am subject to all or any of the above checked penalties. understand any false statements/information made on this form will constitute legal consequences. I also certify that the information contained in this application is true, complete, and correct to the best of my knowledge and is made in good faith

H) Patient's signature:_________________________________Date: ________________________

I) Patient's legal guardian's signature:______________________Date: ________________________

All Forms must be signed by the patient or patient's legal guardian. No third-party requests will be accepted.