Juan L. Sotomayor, MD, PC

ALLERGY & ASTHMA

Diagnostic Office

Appointment & No-Show Policy

We value your time and ours. In order to provide timely care to all patients, we kindly ask that you review, follow and sign the policy below.

Appointment Reminders

Our office uses TalkSoft/ReSpring to send appointment reminders via phone call, email and/or text message. These reminders are provided as a courtesy only. It is ultimately the patient's responsibility to know the date and time of their appointment.

Cancellations & Missed Appointments

We understand that emergencies and unexpected situations occur. If you are unable to attend your appointment, please notify our office as soon as possible.

A minimum of 24 hours' notice is required to cancel or reschedule most appointments.

Please note: There is a separate policy and procedure for testing appointments, which will be reviewed with you during your first visit.

No-Show & Late Cancellation Fees

If you fail to arrive for your appointment or cancel with less than 24 hours' notice, the following **non-covered fees** will be applied to your account:

- **$150.00** - Consultation Appointments
- **$75.00** - Testing Appointments
- **$40.00** - All Other Appointments
- **$10.00** - IT Appointments

These fees are not covered by any insurance carrier and are the responsibility of the patient.

For non-acute visits, no-show fees must be paid in full before future appointments can be scheduled.

Repeated Missed Appointments

Due to high patient demand and limited appointment availability:

- Same-day non-emergent cancellations will result in a fee
- Repeated no-shows or cancellations with less than 24 hours' notice may result in dismissal from the practice.

By signing below, I acknowledge that I have received, read and understand the Appointment and No-Show Policy for Allergy & Asthma Diagnostic Office, and I agree to comply with the terms outlined. I fully understand that these policies help our office provide timely, respectful care to all patients.

Patient name (Printed): _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if < 18yrs): _____ Date: _____