



Sound Dermatology

# NO-SHOW AND CANCELLATION POLICY

## Sound Dermatology, LLC

Owner/Clinical Director: Joshua Schell, APRN

State: Kansas

Effective Date: March 02, 2026

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## 1. PURPOSE

Sound Dermatology is committed to providing timely dermatologic care to all patients. Missed appointments and late cancellations limit access to care for other patients and disrupt clinic scheduling.

This policy outlines expectations regarding appointment cancellations and missed visits.

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## 2. CANCELLATION REQUIREMENTS

Patients are required to provide at least **24 hours' notice** to cancel or reschedule an appointment.

Notice may be provided by:

- Telephone
- Secure patient portal (if applicable)
- In person

Messages left after business hours will be considered received on the next business day and may not satisfy the 24-hour notice requirement.

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## 3. NO-SHOW DEFINITION

A “no-show” includes:

- Failure to arrive for a scheduled appointment
  - Arrival **more than 15 minutes late (without notice)** resulting in inability to be seen
  - Cancellation with less than 24 hours' notice
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## 4. NO-SHOW FEES

Missed appointments or appointments canceled with less than 24 hours' notice (including same-day appointments) **may be subject to a no-show fee of \$30 per occurrence.**

No-show fees are not billable to insurance and are the patient's responsibility.

These fees may be charged to the credit card on file in accordance with the Financial Policy.

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## 5. REPEATED MISSED APPOINTMENTS

Repeated missed appointments may result in:

- Requirement to prepay future visits
- Restriction on advance scheduling
- Dismissal from the practice in accordance with the Termination of Patient Relationship Policy

Patients requiring ongoing treatment or monitoring for chronic dermatologic conditions are responsible for maintaining follow-up appointments as recommended. Failure to maintain appropriate follow-up may affect treatment outcomes.



## 6. EMERGENCIES

No-show fees may be waived at the discretion of Sound Dermatology in cases of:

- Medical emergencies
- Severe weather
- Unforeseeable circumstances

Documentation may be requested when appropriate.

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## 7. ACKNOWLEDGMENT

By signing below, I acknowledge that I have read and understand the No-Show and Cancellation Policy and agree to comply with its terms.

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Signature of Patient/Personal Representative

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Date

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Printed Name

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Relationship to Patient