PODIATRY 1st

JAMES ANDERSON D.P.M.
NATALIE MOTA D.P.M.
JOHN LINDSAY D.P.M.

Cancel, Reschedule, and No-Show Policy

Thank you for trusting Podiatry 1st with your foot and ankle medical care. When you schedule an appointment with Podiatry 1st, we set aside enough time to provide you with quality care. In the event you would need to cancel or reschedule an appointment, please contact our office as soon as possible, and **no later than 24 hours prior to your appointment**. This will give our office adequate time to schedule other patients who may be waiting for an appointment. Please see our Cancellation/No Show Policy below:

• Effective February 1st, 2018 established patient who fail to show or cancels/reschedules an appointment and has not contacted our office without **at least 24-hour notice** will be considered a No Show and may be required to put a credit card on file to make another appointment to be charged a $35.00 no show fee in the event of a consecutive occurrence.

• Any established patient who fails to show or cancels/reschedules an appointment without a **24-hour advance notice** may be charged a $35.00 fee after a second occurrence.

• If a third No Show or cancellation/reschedule with **no 24-hour notice** should occur the patient may be dismissed from Podiatry 1st.

• Any new patient who fails to show for their initial visit will be required to put a credit card on file to make another appointment. Any new patient who fails to show for initial appointment for a second time will not be able to reschedule.

• The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

• As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager. You may contact Podiatry 1st 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message. Messages left at either location are acceptable.

Podiatry 1st - O'Fallon, Columbia, and St. Louis - (618)277-9533

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature Relationship to Patient

C. James Anderson, DPM | Natalie Mota, DPM | John Lindsay, DPM
717 Insight Ave Suite 100, O'Fallon, IL 62269 | 1000 Eleven South, Suite 3A, Columbia, IL 62236
11710 Old Ballas Road, #110, St. Louis, MO 63141
(p) 618-277-9533 (f) 618-277-9540 | www.Podiatry1st.com

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Prescription Consent Form

Consent to Obtain Patient Medication History. Patient Medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____ _____

Patient/Parent/Guardian Signature Date

_____

Printed Patient/Parent/Gaudian Name

By signing this consent form, you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

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