University Pain & Spine Center
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APPOINTMENT POLICY AGREEMENT

I, _____ _____ acknowledge and agree to University Pain Medicine Center (UPMC), University Pain & Spine Center(UPSC), affiliated providers, and staff (collectively Referred to as, "The Practice") appointment no-show and cancellation policy. I understand that if I need to cancel or reschedule my appointment, I must do so at least 24 business hours in advance. Business hours are Monday through Friday, 9:00 a.m. - 5:00 p.m. (excluding federally recognized holidays).

No-Show and Cancellation Fees: If I fail to cancel any medical appointment scheduled with The Practice at least 24 business hours before the scheduled visit time, or if I do not attend without providing verbal notification, I will be considered a no-show. A non-refundable fee of $85 will be charged to my account or any credit card on file for each occurrence. I understand that I am responsible for paying all fees associated with violations of this policy.

Fee Exemptions: I understand that if I am legally or contractually exempt from no-show or cancellation fees due to insurance policy provisions or government mandates, I must notify The Practice in writing and provide proof of this exemption. In such cases, I will not incur a financial obligation for missed appointments.

Discharge and Release of Liability: I understand that if I have more than two cancellations or no-shows within a six-month period, my non-compliance with scheduled visits will serve as my notification to terminate the patient-provider relationship with The Practice. I acknowledge that failure to comply with this policy constitutes my voluntary discharge from The Practice's care. As a result, I will be discharged from The Practice and will no longer be considered a patient of The Practice, its physicians, or designee(s). By signing below, I agree that my discharge from care due to non-compliance with this agreement releases The Practice, including its physicians, employees, and agents, from any liability and any right to civil litigation, including claims of malpractice, negligence, or other civil claims, arising directly or indirectly from my discharge.

By signing below, I confirm that I have read, understood, and agree to the terms outlined in this policy, including the no-show and cancellation fees, discharge conditions, release from liability, and voluntary discharge acknowledgment.

_____ _____

Patient or Responsible Party Signature | Date