PETITION TO WAIVE FEE
NO SHOW/LATE CANCELLATION

STILLPOINT

As enumerated in our Office Policy, our office reserves the right to charge a fee for missed appointments or the cancellation of an appointment without at least 24-hour notice.
If you were unable to attend your appointment due to a legitimate emergency and believe this fee should be waived **please complete this form and submit it to our office for consideration.**

PATIENT INFORMATION **Today's Date: _____**

Patient Name		DOB (mm/dd/yyyy)
Patient Address	City, State, Zip	Patient Telephone
Email (optional)		

APPOINTMENT INFORMATION

1. What was the date and time of the missed appointment? Date: _____ Time: _____
2. With whom was the appointment scheduled? _____
3. Which fee are you trying to have waived? ..... ☐ No Show ☐ Late Cancelation

EXPLANATION

Please state the reason you believe we should waive your fee: _____

_____

_____

_____

_____

_____

MAIL COMPLETED FORM TO:	Please be sure to include any documentation to substantiate your explanation for missing your appointment.
Stillpoint Mental Health Associates ATTN: Appeals 201 East Ogden Avenue, Suite 116 Hinsdale, IL 60521-3655	**Note:** Submission of this form does not automatically waive your missed appointment fee. A full copy of our Office Policy is available on our website. http://www.stillpointmentalhealth.com

I hereby certify that the above statements are true and correct to the best of my knowledge.

Signature: _____ **Date:** _____