Crutchfield Dermatology

Patient Satisfaction Agreement and

No-Show and Cancellation Policy

PLEASE PRINT PATIENT'S NAME _____ **Date of Birth** _____

Patient Satisfaction Agreement

Dr. Charles Crutchfield III, MD and Crutchfield Dermatology, PA (collectively called "Crutchfield Dermatology") hold your satisfaction as our top priority. If at any time during your communication with our staff, your treatment by our medical professionals, or any service follow up you have a question, issue, or concern, we want to do everything possible to answer your questions or address your issues and concerns.

We also take pride in Crutchfield Dermatology's reputation for excellence and our great standing in the community, and we are committed to earning the positive reputation and maintaining that standing every day. As we agree to work as hard as we can to meet your satisfaction, you agree to report any question, issue, or concern you have related in any way to the care we have provided to our Satisfaction Director at (651) 209-3600 or at satisfactiondirector@crutchfielddermatology.com. You further agree to follow the following process ("Patient Satisfaction Agreement Procedures") prior to any disclosure of the matter by you to third parties.

First, you agree to provide Crutchfield Dermatology 30 days from the time you provide notice of your concern to our Satisfaction Director as described above. Second, Crutchfield Dermatology is a proud member of the Better Business Bureau. In the event we are unable to resolve a matter to your satisfaction within 30 days as described above, you agree to submit your concern to the Better Business Bureau for a determination regarding your concern. Finally, if you believe your concern remains inadequately addressed after these time periods and processes, you agree to provide Crutchfield Dermatology with a written copy of any communication you plan to disseminate regarding an unresolved issue prior to doing so. You also authorize the Clinic to verify the source of any such communication from you to ensure concerns and issues are properly reported to permit us to address such matters in the future. You further agree that a failure to follow the above policy entitles Crutchfield Dermatology to equitable relief.

No-Show and Cancellation Policy

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointments with Crutchfield Dermatology are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary costs and to contain our fees, we maintain a No Show/Cancellation Policy for all our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance. Cancellations must be made between 8 a.m. and 5 p.m. on workdays at least one full business day before the scheduled appointment. Cancellations must be done over the telephone by speaking directly to one of our scheduling professionals, who will provide a cancellation number. Patients will not be charged for an office visit if cancellation is made 24 business hours before their appointment and a cancellation number is received.

In the event an appointment is missed or cancelled with less than 24 hours notice or no notice, a $75 charge will be billed. If a second no-show or same day cancellation occurs, we reserve the right to terminate the patient-doctor relationship.

This policy is in effect for all appointments at our office, including clinical, laboratory, cosmetic, and phototherapy appointments. Again, all no-shows or same-day cancellations will be invoiced $75 if not cancelled with a 24 business hour notification with a received cancellation code.

Finally, you acknowledge that you have had an opportunity to review this agreement with the counsel of your choosing. This agreement shall be valid and enforceable for five years from Crutchfield Dermatology's last date of service to you. Crutchfield Dermatology reserves the right to modify any policies without notice.

My signature below indicates that I have read and understand these policies.

*X*_____ _____

Patient or Responsible Party Signature **Today's Date**