



Sanctuary for Healing and Integration, PLLC (SHIN)  
Child & Adolescent and Adult Psychiatry  
860 East 4500 South, Suite 302  
Salt Lake City, UT 84107

## MISSED APPOINTMENT POLICY

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

I, \_\_\_\_\_, understand and agree that I am personally responsible for payment of appointments missed without notice in advance, and that it is not the responsibility of the insurance carrier or any third party payer to make payments on my missed appointments.

Missed appointments are billed at the same fee as my regular office visits, and I am aware of the existing fee presently in effect.

A photocopy of this form shall be as valid as the original.

\_\_\_\_\_  
*Patient (if over 18 years old)*

\_\_\_\_\_  
*Parent/Guardian*

\_\_\_\_\_  
*Date Signed*

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