The Center for
RHEUMATOLOGY LLP
Diagnosis, Care and Research

MRN: ____________

PETITION TO WAIVE FEE

Per our Office Policy, our office reserves the right to charge a fee for missed appointments 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? ____

EXPLANATION

Please state the reason your No-Show Fee should be waived: ______________________________

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MAIL COMPLETED FORM TO: Albany: The Center for Rheumatology 4 Tower Pl Fl 8 Albany NY 12203 Saratoga: The Center for Rheumatology 6 Care Lane, Suite 101 Saratoga, NY 12866	Please be sure to include any documentation to substantiate your explanation for missing your appointment. **Note:** Submission of this form does not automatically waive your missed appointment fee.

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

Signature:____**Date:** ____________________