



Crooked Tree  
Wellness Clinic

**CROOKED TREE WELLNESS CLINIC**

Little Traverse Bay Bands of Odawa Indians  
2390 Mitchell Park Drive, Unit D  
Petoskey, MI 49770  
P: 231-242-1760

**ADULT PATIENT REGISTRATION**

*For the Little Traverse Bay Bands of Odawa Indians (LTBB) to provide efficient health services while following federal regulations, you must complete this form and return it to our Central Registration. If completed, the information provided will assist the Crooked Tree Wellness Clinic in the best course of healthcare and available resources.*

FULL LEGAL NAME: \_\_\_\_\_

PREFERRED NAME/ALIAS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

SEX ON BIRTH CERTIFICATE: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

CITY AND STATE OF BIRTH: \_\_\_\_\_

HOMELESS?      HOMELESS SHELTER       TRANSITIONAL       OTHER: \_\_\_\_\_

CURRENT ADDRESS: \_\_\_\_\_ ADDRESS 2: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

ARE YOU A DESCENDANT OR CITIZEN OF A FEDERALLY RECOGNIZED TRIBE?       YES       NO

TRIBAL AFFILIATION: \_\_\_\_\_

ENROLLMENT NUMBER OR LIST DESCENDANT: \_\_\_\_\_

DO YOU SPEAK PROFICIENT ENGLISH?      YES       NO

DO YOU REQUIRE AN INTERPRETOR?      YES       NO

DO YOU IDENTIFY AS HISPANIC OR LATINO?      YES       NO

DO YOU HAVE ACCESS TO THE INTERNET?      YES       NO

IF YES, WHERE?      HOME       WORK       SCHOOL       OTHER: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER(S): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HRN#: \_\_\_\_\_

NEXT OF KIN CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
PHONE NUMBER(S): \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

PARENTAL INFORMATION  
MOTHER'S MAIDEN NAME: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_ DECEASED?: \_\_\_\_\_  
FATHER'S LEGAL NAME: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_ DECEASED?: \_\_\_\_\_

INSURANCE INFORMATION:  
INSURANCE TYPE?  MEDICAL  DENTAL  VISION  
MEDICARE? IF YES, ID# \_\_\_\_\_  
MEDICAID? IF YES, ID# \_\_\_\_\_  
PRIVATE INSURANCE? IF YES, NAME: \_\_\_\_\_  
POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
POLICY HOLDER'S NAME: \_\_\_\_\_  
POLICY HOLDER'S DATE OF BIRTH: \_\_\_\_\_

EMPLOYMENT STATUS:  PART-TIME  FULL-TIME  RETIRED  UNEMPLOYED  
 MIGRANT OR SEASONAL WORKER  SELF-EMPLOYED  
EMPLOYER'S NAME: \_\_\_\_\_ EMPLOYER'S PHONE: \_\_\_\_\_  
EMPLOYER'S ADDRESS: \_\_\_\_\_

MILITARY STATUS:  NOT APPLICABLE  ACTIVE DUTY  RESERVES  
 NATIONAL GUARD  RETIRED  
BRANCH: \_\_\_\_\_ ENLISTMENT DATE: \_\_\_\_\_  
DISCHARGE DATE: \_\_\_\_\_ REASON FOR DISCHARGE: \_\_\_\_\_

HRN #: \_\_\_\_\_



# Crooked Tree Wellness Clinic

## Insurance Attestation

I, \_\_\_\_\_, confirm that I have Michigan  
(Print Name)  
Medicaid (or managed care plan with Michigan Medicaid) as my only, or primary, form of  
insurance.

- I understand that Crooked Tree Wellness Clinic is only able to provide medical care and services as long as Medicaid is my primary insurance provider. If I obtain other insurance, I will no longer be eligible for services at this office.
- I will notify Crooked Tree Wellness Clinic immediately of any changes in my insurance coverage status, or if I obtain insurance coverage from another source or carrier.
- If it is found that I have received care or services at Crooked Tree Wellness Clinic while covered by insurance other than Medicaid, I will be financially responsible for associated charges.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient DOB

\_\_\_\_\_  
HRN



# Crooked Tree Wellness Clinic

Little Traverse Bay Band of Odawa Indians  
2390 Mitchell Park Drive, Unit D  
Petoskey, MI 49770  
Phone: 231-242-1760  
Fax: 978-367-5563

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

I authorize CTWC to:  Disclose to  Receive from  Both Disclose to and receive from

Name: \_\_\_\_\_ Phone/Fax #: \_\_\_\_\_

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

the following information relative to treatment received from \_\_\_\_\_ to \_\_\_\_\_  
start date of services requested End date of Services requested

### PLEASE CHECK REQUESTED ITEM(S):

- Laboratory Reports  Dental Records  Immunization Record  Complete Medical Record (designated record set)
- Behavioral Health  Alcohol and Substance Abuse Records  Dental Images  Diabetes Management
- Face Sheet  Medication Records  Other: \_\_\_\_\_
- Test Result(s) of: \_\_\_\_\_

The purpose for this request:  Legal  Insurance  Personal  Continuation of Care

Other \_\_\_\_\_

### By signing this authorization form, I understand that:

- My health information may be shared electronically.
- I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment or health care operations, or other disclosures.
- The sharing of my health information will follow state and federal laws and regulations.
- I understand that the information in my health record may include information related to sexually transmitted disease, acquired or mental health services, and treatment of alcohol or drug abuse.
- I can withdraw my consent at any time; however, the revocation will not apply to information that has already been released in response to this authorization.
- This authorization of release of information will expire on \_\_\_\_\_ or one year after the date signed if not specified.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian/Legal Representative

\_\_\_\_\_  
Date of Signature

### FOR OFFICE USE ONLY

Staff Person Releasing Information: \_\_\_\_\_

Date Information Released: \_\_\_\_\_

Record #: \_\_\_\_\_



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## **PATIENT CONSENT FORM**

Crooked Tree Wellness Clinic is committed to providing highly qualified services and ensuring a holistic approach for all Anishinaabe by respecting and intertwining both modern and traditional healing.

We want you to understand your right and responsibilities while receiving care within our organization. If you have any questions about this form, please ask prior to signing. If you are a parent/legal guardian of a child, please read this agreement with the understanding that “I” and “me” means the child.

### AUTHORIZATION TO GIVE MEDICAL CARE-CONSENT TO TREAT:

I consent to outpatient care from Crooked Tree Wellness Clinic including medical treatment, examination, and routine diagnostic procedures—including routine laboratory work and administration of medication as deemed medically necessary in the professional judgement of my medical provider. I also understand that I have the option to refuse any health care services at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

### TELEMEDICINE:

I understand that Crooked Tree Wellness Clinic may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a remote site at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

**Possible Risks:** Just like any other medical procedure, there are potential risk associated with the use of telemedicine. These risks include but may not be limited to:

- Information being transmitted may have poor sound or image quality to allow for appropriate medical decision making by the provider
- Delays in medical evaluation and treatment could occur due to equipment failure
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;
- In very rare instances, there could be a security breach causing your PHI information to be leaked

AUTHORIZATION TO RELEASE INFORMATION: Based on the Privacy Act of 1974, P.L. 93-579, I hereby authorize the release of my personal health information (PHI) for referral to health care providers outside of Crooked Tree Wellness Clinic for the purposes of healthcare, treatment, and insurance claims, and any other community resources that assist me with my healthcare

needs; not excluding substance abuse, mental health, HIV/AIDS, STD's, etc. I authorize the release of my PHI to my insurers as necessary for determination and payment of benefits, including Medicare and Medicaid.

HEALTH INFORMATION EXCHANGE: As part of the Little Traverse Bay Bands Health Department, Crooked Tree Wellness Clinic endorses, supports, and participates in Health Information Exchange (HIE) as a patient-centered care approach to improve the overall well-being of our patients. HIE allows us to efficiently share clinical information among the other providers within the LTBB Health Department (which includes Behavioral Health, Dental, and Community Health programs) to be able to treat the mind, body, and soul of our patients.

This model helps foster communication and shared decision-making among your care team about treatment options that will best address your healthcare needs. I understand that I can submit a written request for restrictions with the Privacy Officer or Health Information Management (HIM) staff at any time.

NOTIFICATION OF PRIVACY: I have read and acknowledge receipt of the Notice of Privacy Practice.

PATIENT RIGHTS AND RESPONSIBILITIES: I have read and acknowledge receipt of the Patient Rights and Responsibilities

CONSENT TO TREAT: I have read and understand the information provided above regarding my care here at the Crooked Tree Wellness Clinic, and all of my questions have been answered to my satisfaction.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM  
Patient or Patient Representative

**If Not the patient:** Relationship to Patient

\_\_\_\_\_

FOR OFFICE USE ONLY

Patient Rec'd Copy of NPP

Patient Rec'd Copy of

PRR CHART \_\_\_\_\_



# Crooked Tree Wellness Clinic

LITTLE TRAVERSE BAY BANDS HEALTH DEPARTMENT  
Crooked Tree Wellness Clinic

## RELEASE OF PROTECTED HEALTH INFORMATION

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment or health care operations, or other disclosures. I also have the right to authorize the release of my protected health information to members of my family, friends, and/or any person that is involved in my care.

I authorize the following person(s) to obtain my health information:

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\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE  
(IF LEGAL REPRESENTATIVE, STATE RELATIONSHIP TO PATIENT)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
EXPIRATION DATE OF AUTHORIZATION

\_\_\_\_\_  
WITNESS NAME & SIGNATURE

\_\_\_\_\_  
CLINIC USE ONLY - DO NOT WRITE BELOW THIS LINE

DATE RECEIVED: \_\_\_\_\_

CLINIC INTAKE INITIALS: \_\_\_\_\_

CTWC HRN \_\_\_\_\_



## **NOTICE OF PRIVACY PRACTICES**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

Crooked Tree Wellness Clinic is required by law to maintain the privacy of every patient's health information, as required by the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996.

This notice describes how medical information about you may be used and how you can get access to this information. We are required by law to maintain the privacy and security of your protected health information (PHI). This notice applies to the PHI in our possession including the medical records generated by us.

As required by "HIPAA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **PAYMENT** means such activities as obtaining reimbursement for our services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, and utilization review. An example of this would be an internal assessment review.

We may also create and distribute unidentified health information by removing all references to individually identifiable information.

We will not use or share your information other than as described here unless you tell us we can in writing. You may revoke such authorization in writing, and we are required to honor and abide by that written request.

Although your health records are the physical property of Crooked Tree Wellness Clinic, the information belongs to you.



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**As our patient you have the following rights when it comes to your health information:**

- The right to revoke your written authorization to use or disclose health information. This does not apply to health information already disclosed or used or in circumstances where we have acted on your authorization or the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy of the policy itself.
- The right to reasonably request to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and receive a copy of your PHI.
- The right to request an amendment/correction to your PHI.
- The right to receive a listing of certain disclosures the LTBB Health Department has made of your PHI.
- The right to obtain a paper copy of the Crooked Tree Wellness Clinic Notice of Privacy Practices from us upon request.

If you would like to exercise any of these rights, please submit a request in writing to our Privacy Officer.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI.

This notice is effective as of June 25, 2020, and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new Notice provisions effective for all PHI that we maintain. If we have made any change to the Notice of Privacy Practices, you will be notified during your next visit or by mail. It is required that you also sign a copy of the Notice of Privacy Practices on an annual basis.

You may file a complaint with us if you believe we have violated your privacy right. This can be done by notifying our Privacy Officer in writing of your complaint. Please use the Little Traverse Bay Bands of Odawa complaint form. We will not retaliate against you for filing a claim. You may file a complaint with the Secretary of Health and Human Services if you believe we have violated your privacy right.

For more information about HIPAA:  
The US Department of Health & Human Services  
Office of Civil Rights  
200 Independence Ave SW  
Washington, D.C. 20201



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### **Patient Rights and Responsibilities**

As a patient of Crooked Tree Wellness Clinic, you have the right to:

- Receive complete and current information about your diagnosis, treatment, and prognosis in terms you can be reasonably expected to understand
- Participate actively in determining a course of treatment for yourself
- Receive information that you need in order to give informed consent for any proposed procedure or treatment, including information about the risk, benefits and alternative to the proposed procedure or treatment
- Refuse treatment and be told what affect this may have on your health, and to be informed of the other potential consequences of refusal
- Request a second opinion from another physician
- Receive considerate and respectful care in a clean and safe environment
- Know by name the physicians, nurse and other staff members responsible for your care
- Refuse to take part in any research or educational projects
- Have privacy while in the Clinic, and confidentiality of all information and records regarding your care
- Designate an individual to represent you in making decisions regarding your treatment and health care
- Be provided with complete information about the Clinic's policies regarding patient rights, patient complaints and advance directives

### **Your Responsibilities**

Rules and regulations regarding conduct are necessary to ensure that all patients are treated fairly and feel secure while being seen at the Clinic. Your cooperation in these responsibilities will help us provide quality care and service. Please....

- Provide accurate and updated information for your file.
- Follow the plan of care you, your physician, and your health care team have agreed upon
- Ask questions of your caregivers and communicate any concerns or wishes you may have.
- Respect the privacy and confidentiality of the other Clinic patients.
- Respect the staff of Crooked Tree Wellness Clinic by using considerate communication and behavior at all times. Yelling, cursing, and inappropriate language/behavior will not be tolerated.

If you have any questions about your rights, please contact the

LTBB Health Director, Jody Werner at 231-242-1612.

**HEALTH HISTORY**  
(Confidential)

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_

**Symptoms: Check (✓) symptoms you currently have or have had in the past year**

<b>General</b>	<b>GASTROINTESTINAL</b>	<b>EYE, EAR, NOSE, THROAT</b>	<b>Reproductive Health</b>	<b>Reproductive Health</b>	
Chills	Poor Appetite	Bleeding gums	Breast Lump	Abnormal Pap	
Depression	Bloating	Blurred vision	Erection difficulties	Bleeding between periods	
Fainting	Bowel Changes	Crossed eyes	Lump in testicles	Breast Lump	
Fever	Constipation	Difficulty swallowing	Penis discharge	Extreme menstrual pain	
Forgetfulness	Diarrhea	Double vision	Sore on penis	Hot Flashes	
Headache	Excessive hunger	Earaches	<b>CARDIOPULMONARY</b>	Nipple discharge	
Difficulty sleeping	Excessive thirst	Ear Discharge		Chest Pain	Painful intercourse
Weight loss	Gas	Hay fever		High Blood Pressure	Vaginal discharge
Nervousness	Hemorrhoids	Hoarseness		Irregular heart beat	Date of last menstrual period?
Numbness	Indigestion	Hearing loss		Low Blood Pressure	Date of last Pap Smear?
Sweats	Nausea	Nosebleeds		Poor circulation	Have you had a mammogram?
<b>MUSCLE/JOINT/BONE</b>	Rectal bleeding	Persistent Cough		Rapid Heart Beat	Are you pregnant?
Pain/Weakness/ Numbness in:	Stomach pain	Ringing in ears		Selling of ankles	
Arms	Vomiting	Sinus problems		Varicose Veins	
Back	Vomiting Blood	Vision—Flashes		Shortness of breath	
Feet	<b>SKIN</b>	Vision—Halos			
Hands	Bruise Easily	<b>GENITO-URINARY</b>			
Hips	Hives	Blood in Urine	<b>Last Colonoscopy/Cologuard</b>		
Legs	Itching	Frequent urination	Results:		
Neck	Change in moles	Lack of bladder control			
Shoulders	Rash	Painful Urination			
	Scars				
	Sore that won't heal				

**Conditions: Check (✓) conditions you have or have had in the past**

HIV/AIDS	Cancer	Glaucoma	Kidney Disease	Pneumonia	Tonsillitis
Anemia	Cataracts	Goiter	Liver Disease	Polio	Tuberculosis
Anxiety	Chicken Pox	Gout	Measles	Prostate Problem	Ulcers
Arrhythmia (irregular heartbeat)	Chemical dependency	Heart Disease	Migraine Head-aches	Prenatal substance exposure	Vaginal Infections
Arthritis	Depression	Heart Murmur	Miscarriage	Sexually transmitted	Other:
Asthma	Diabetes	Hepatitis	Mononucleosis	Shortness of breath	Other:
Bleeding Disorders	Eating Disorder	Hernia	Multiple Sclerosis	Stroke	Other:
Breast Lump	Emphysema	Herpes	Mumps	Suicide Attempt	Other:
Bronchitis	Epilepsy	High Cholesterol	Pacemaker	Thyroid Problems	Other:

**HEALTH HISTORY**  
(Confidential)

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Medication (s)	Dose (e.g. mg/pill)	How many times per day?

Allergy	Reaction or Side Effect

**Family History:** Please indicate with a check (✓) who in your family has had the following conditions. In the first column please indicate their living status. L=Living, D= Deceased, U=Unknown.

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Cancer (Type)	Colon Polyps	Depression	Other
Mother		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Father		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Siblings		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandmother		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandfather		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Grandmother		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Grandfather		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

Other Family Members Information (please write in)

**HEALTH HISTORY**  
(Confidential)

**Hospitalizations**

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion  Yes  No

If yes, please give approximate dates:

Serious Illness/Injuries	Date	Outcome

**Women's Health**

Number of pregnancies	Number of abortions
Number of Deliveries	Number of Miscarriages

**Social History:**

Caffeine	<input type="checkbox"/> Energy Drinks <input type="checkbox"/> Coffee <input type="checkbox"/> Pop/Soda <input type="checkbox"/> Other	Marijuana <input type="checkbox"/> Medical or <input type="checkbox"/> Recreational
Tobacco	<input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Former : quit: If current # of packs/day # of years	Drugs If yes, please describe:
Other Tobacco	<input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew Are you interested in quitting? <input type="checkbox"/> Yes <input type="checkbox"/> no	Exercise: Do you exercise regularly:
Alcohol	If yes, # of drinks per week	

**Occupational Concerns check (✓) if your work exposes you to the following:**

Stress	
Hazardous Substances	
Heavy Lifting	
Other	
Your Occupation:	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Reviewed by

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



## Crooked Tree Wellness Clinic

2390 Mitchell Park Dr. Suite D  
Petoskey, MI 49770  
231.242-1760 (p)  
978.367.5563 (f)

### Cancellations, No Shows, and Late Arrivals

- CTWC requires a 24-hour notice for appointment cancellation. If this is not possible, you must notify CTWC of the need to cancel as soon as possible.
- Cancellations made within 24 hours of a scheduled appointment will be considered a late cancellation.
- Arriving 10 (or more) minutes past the given arrival time is considered a no-show. You will be asked to reschedule the appointment to another day.
- Repetitive no-shows and cancellation may result in termination of the patient-provider relationship.