Lindner Center of HOPE
Professional Associates

Late Cancellation/No Show Waiver Request

Patient Name:_____ Phone:_____

Patient D.O.B.:_____ Date of service: _____/_____/_____

Clinician Name:_____

I am requesting a waiver of the No Show/Cancellation Fee that was applied to the above date of service for the following reason:

1. I called the scheduling number 513-536-0570 greater than 24 hours before my appointment.
   - Phone Number from which I called: _____(required)
   - Date and time I called: _____(required)

2. The cancellation or no show is caused by death of a family member
   - Name of the Deceased: _____(required)
   - Relationship to the Deceased: _____(required)
   - Funeral Home/Mortuary Name: _____(required)
   - Funeral Home Phone Number: _____(required)
   - Other documentation: _____

3. I was receiving treatment in a hospital, emergency room, or urgent care facility.
   - Name of Hospital or Medical Facility_____(required)
   - Date of admission: _____(required)
   - Date of discharge_____(required)

By my signature below, I certify that everything I have stated on this application is true.

Signature (patient/applicant): _____ Date:_____

Reviewed and approved by Clinical Director of Outpatient Service? ___Yes___ No

Signature_____

If no, reason: _____

Office Use Only: Applicant notified of approval or denial on Date: _____ MRN#_____

How Notified? _____ Staff member: _____

Charge removed in Epic on_____ Charge removed in IDX on_____

**Forward Waiver Request to Medical Records for IDX adjustment & scanning.