Sunflower Mountain Mental Health
805 Eagleridge, Suite 140
Pueblo, CO - 81008

* 2025 SMMH Attendance and Cancellation Policy

Sunflower Mountain Mental Health LLC
805 Eagleridge Boulevard
Suite 140
Pueblo, CO 81008
Phone: (719) 679-5022
Fax: (719) 888-1673

Patient Name: *

Patient Date of Birth: *

Please read the following conditions of attendance and cancellation in connection with receiving services at Sunflower Mountain Mental Health LLC.

We understand that there are times when you must miss an appointment due to emergencies or personal obligations. However, this prevents our practice from providing care to another patient needing treatment. Cancelling your appointment will give another patient the possibility of accessing timely medical care. Please call or text the practice directly at (719) 679-5022 should you need to cancel or reschedule. Leave a voicemail if no one is available to take your call. Please do not use the calendar or patient portal to make changes to your appointment time on the day of the appointment as this request may not be communicated to the Practice in a timely manner. If it is at least 24 hours prior to your appointment, you may use the calendar or patient portal to request to re-schedule your appointment. This request will be confirmed at the start of the next business day after your request was received.

LATE CANCELLATION

By signing below, I acknowledge understanding and agreement of the following:

• Failure to cancel an appointment at least 24 hours before the scheduled appointment time will be considered a late cancellation.
• You will be charged a fee of $50, if applicable (patient's with certain insurances will not be charged as prohibited by law, including
Medicaid and Medicare)
• Late cancellation fees must be paid before the appointment is rescheduled.
• Three late cancellations within a 6 month period may result in discharge from the clinic, whether or not a fee was charged. See the
Discharge / Termination from Practice Policy for further details regarding this process.

NO-SHOW

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By signing below, I acknowledge understanding and agreement of the following:

• A no-show is when a patient fails to arrive for their scheduled appointment time.
• You will be charged $150 for a new patient intake and $75 for a follow-up appointment, if applicable (patient's with certain insurances will
not be charged as prohibited by law, including Medicaid and Medicare)
• For a new patient intake, you will not be allowed to reschedule after 2 no-shows.
• Three no-shows within a 6 month period may result in discharge from the clinic, whether or not a fee was charged. See the Discharge / Termination from Practice Policy for further details regarding this process.

LATE ARRIVAL

By signing below, I acknowledge understanding and agreement of the following:

• Late arrival is when a patient arrives 5 minutes or later to their scheduled appointment time.
• It will be up to the healthcare provider's discretion whether or not to continue with the appointment as scheduled if the patient arrives late.
The healthcare provider reserves the right to re-schedule the appointment if there is not adequate time remaining to complete the appointment.
• Three late arrivals within a 6 month period may result in discharge from the clinic. See the Discharge / Termination from Practice Policy for
further details regarding this process.

We understand that life happens and there may be times when emergencies occur that do not allow you enough time to notify the Practice that you need to cancel your appointment. Under special circumstances, your provider may make the decision to waive any fees if they deem it appropriate.

Your credit card on file will be charged the above-mentioned fees when the outlined situations occur and we will email you a receipt. Further appointments will not be scheduled until your balance is resolved.

Your signature below indicates that you have read, understand, and agree to the terms and conditions outlined in this policy.

Patient Signature (Patient if age 15+ or Parent/Guardian Signature, if applicable): *

Parent/Guardian Name (if applicable):

Relationship to Patient (if not patient):

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Date Signed: *