# ***LSN Program Monthly Participation Agreement and Missed Appointment Authorization***

Patient Name (Print): _____

Date of Birth: _____

**1. Monthly Participation Requirement**

I understand that participation in the LSN Program requires ongoing monitoring and follow-up with my healthcare provider. To support appropriate clinical management and participation in the program, I am expected to complete at least one provider follow-up visit during each calendar month.

I acknowledge that maintaining and attending scheduled appointments is my responsibility.

**2. Missed Appointment Policy**

Complete Care maintains a uniform missed appointment policy that applies equally to all patients, regardless of insurance coverage, including Medicare, Medicaid, commercial insurance, and self-pay patients.

I understand that a $150.00 missed appointment fee may be assessed if I:

- Fail to attend a scheduled appointment without notice (no-show);
- Cancel a scheduled appointment and do not reschedule and complete the visit within the same calendar month; or
- Repeatedly fail to maintain scheduled monthly follow-up appointments required for participation in the LSN Program.

This fee is assessed in connection with reserved appointment time that was not utilized and the associated administrative costs incurred by the practice.

**3. Insurance and Financial Responsibility**

I understand and acknowledge that:

- The $150.00 missed appointment fee is an administrative fee and is not payment for medical services, treatment, monitoring, supplies, medications, or clinical care.
- The missed appointment fee is not covered by insurance.
- The missed appointment fee will not be submitted to Medicare, Medicaid, or any commercial insurance carrier for payment or reimbursement.
- I am personally responsible for payment of this fee.

**4. Credit Card Authorization**

By signing below, I authorize Complete Care to maintain a valid credit card on file.

I authorize Complete Care to charge my card the $150.00 missed appointment fee if I incur a charge under this policy.

Complete Care will make reasonable efforts to notify me regarding missed appointments and provide opportunities to reschedule when appropriate prior to processing the charge.

**5. Voluntary Withdrawal from the Program**

I understand that I may withdraw from the LSN Program at any time by notifying Complete Care.

Withdrawal from the program will end future monthly participation requirements but may affect future treatment recommendations and eligibility for program services.

**Patient Acknowledgment**

By signing below, I acknowledge that:

- I have read and understand this agreement.
- I have had the opportunity to ask questions regarding the monthly participation requirements and missed appointment policy.
- I understand that the missed appointment fee is not a charge for medical services and will not be billed to insurance.
- I understand my financial responsibility for any applicable missed appointment fees.
- I voluntarily authorize Complete Care to charge the payment method maintained on file as described in this agreement.

**Patient Signature:** _____

**Date:** _____

**Complete Care Representative Name:** _____

**Representative Signature:** _____

**Date:** _____