

# Worksite Wellness Center (WWC)



## 2026 Appointment Reminders / Cancellation, No-Show & Financial Responsibility Agreement

Your appointment time is reserved exclusively for you and may directly impact your employer operations, hiring timelines, regulatory compliance, and provider scheduling. Missed appointments result in lost clinical time and administrative cost. It also impacts the greater Reedsburg community members that could have used your scheduled appointment to be seen for their acute needs.

### Notice Required

- A minimum of **24 business hours' notice** from time of your scheduled appointment is required to cancel or reschedule your appointment.
- Cancellations made with less than 24 business hours' notice are considered **late cancellations**.
- Arriving more than **10 minutes late** may be treated as a missed appointment and may require rescheduling if WWC is unable to accommodate you into the schedule that day.

### How to Provide Notice

- WWC is available to receive notices on a 24-hr basis. Should you need to cancel you can do so by contacting WWC at 608-768-3333 and speaking with a staff member.
- In the event you wish to provide notice after hours to WWC, please leave a message with **your time of appointment, date and your contact information** in case staff needs to reach you the following day to reschedule or discuss.

### No-Show Definition

A no-show occurs when a patient fails to appear for a scheduled appointment without providing required notice to WWC.

### Fees

The following fees may apply:

- **No-Show Fee:** \$35.00
- **Late Cancellation Fee:** \$35.00

These fees reflect reserved provider time and administrative expense and helps offset the lost revenue WWC has for the appointment slot you had that could have been offered to another customer.

### Employer Notification and Financial Responsibility

Employers will be billed first unless contractual terms with WWC state otherwise **for employer-sponsored services only** (including but not limited to new hire physicals, injury visits, drug/alcohol testing, DOT exams, hearing and other regulatory testing. The employer or designated company representative will be notified of your no show or late-canceled appointments.

Non-employer sponsored services (i.e. acute care visits) are the individual's sole responsibility for no show / cancellation penalty payments, not the employers.

## Your Financial Responsibility and Collections

- If your employer, carrier, or third party does not pay the missed appointment fee, you agree to be personally responsible for payment.
- Payment of your outstanding balances are required **before any future appointments are scheduled**.
- The clinic reserves the right to require **prepayment for future services** after one (1) missed appointment.
- **Collections:** Unpaid balances are subject to standard collection procedures consistent with clinic policy.
- You will be invoiced by mail for any missed appointment and late cancellation fees which require payment in full within 45 days from the noted invoice date mailed to you.
- A one-time follow-up notice will be sent to you 15 days prior to any further collection actions taken for payment.
- Failure to pay invoiced fees and any remaining unpaid balances may be referred to a licensed collection agency in accordance with federal law and the laws of the State of Wisconsin.

## WWC's Rights to Refuse Services

Repeated **missed appointments** (two or more within 12 months) or **repeated excessive late cancellations** of (four or more within 12 months) may result in limitation, denial and revoked scheduling privileges for future care at WWC's sole discretion.

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## Patient Agreement to Policy Terms

I acknowledge that I have read and understand WWC's Appointment Cancellation, No-Show, and Financial Responsibility Agreement. I understand that missed or late-cancelled appointments may result in fees for which I am personally responsible for and agree to the collection terms noted in this policy. I also consent to receiving appointment reminders by each method I select below. I agree that my employer may also be notified of related missed employer sponsored services appointments noted above.

Patient Name (Printed): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

I consent to being reminded of my appointments by the following methods: Please select all methods below you approve.

Phone Calls  Voicemails (okay to leave at #above).  Email  Text (SMS) – Please note carrier rates may apply.

Employer (if applicable): \_\_\_\_\_

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## Timeline of Agreement Period in Effect

This agreement is effective as of May 1, 2026 and will remain in effect for the calendar year of 2026 unless otherwise indicated below.

Until revoked in writing / indefinite.

Other specific expiration date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy).

Applicable fees within this agreement are subject to change on an annual basis on Jan 1<sup>st</sup> of each calendar year which you will be notified of at time of scheduling.

Effective: May 1, 2026