

Appointment No-Show & Outreach Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

An appointment no-show note documents that a scheduled client did not attend or cancelled late, plus any outreach attempts and a risk-informed next step. No US, Canadian, or Australian statute requires the note itself; the regulated parts are the money (a missed session is a non-service, never billed to a payer) and how long the chart is kept. The front desk records the miss; a clinician signs the risk call.

Appointment details anchor the entry

Do: record the scheduled date and time, service or appointment type, clinician, and setting (office or telehealth).

Pitfall: "missed appointment" with no date or time; months later nobody can reconstruct which slot the entry covers.

Attendance status no-show vs late cancel vs clinician cancel

Do: name the exact event; for a late cancellation, record when the notice arrived.

Pitfall: treating the three as interchangeable; fee policy, payer rules, and the NDIS windows all turn on which one it was.

Outreach attempts date, time, method, outcome

Do: write one line per attempt and keep the call or message log as the evidence trail.

Pitfall: "attempted contact" with no date, method, or outcome proves nothing in an abandonment or adverse-event review.

Risk review same-day outreach for flagged clients

Do: state whether the chart carries risk flags, show same-day outreach happened, and set an escalation trigger with a date.

Pitfall: silence on risk for a flagged client; a blank reads as absence of monitoring, not absence of risk.

Billing and fee decision a non-service, never a claim

Do: record that nothing goes to any payer and whether a client fee applies under your written policy.

Pitfall: a billed missed session is denied (CARC 204) and treated as a false claim, the pattern behind real settlements.

Next step owner and date

Do: reschedule with a date, send an attendance letter, arrange a welfare check, or start a documented termination process.

Pitfall: a bare "will follow up"; the next reviewer, and the next clinician, need something they can verify.

Signature and credentials who recorded, who decided

Do: the front desk signs the factual miss; a clinician signs the risk judgment and outreach decision, each dated.

Pitfall: a front-desk-only entry that quietly carries a clinical judgment no clinician ever signed.

Before it goes in the chart

- ☐ Status named: no-show, late cancellation, or clinician cancellation
- ☐ Every outreach attempt dated, with method and outcome
- ☐ Risk reviewed; same-day outreach shown for flagged clients
- ☐ No claim to any payer; fee decision per written policy
- ☐ Next step has an owner and a date
- ☐ Factual entry and clinical judgment each signed

Drafting with AI

Give the scheduled slot, what happened, and your attempts so far; the note needs status, dated outreach, risk, and a next step.

"Draft a no-show and outreach note: 07/21 2 PM telehealth session missed, voicemail 2:12 PM, portal message 4:40 PM, safety plan on file, hold next week's slot: ..."

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

75 to 200 words

very short operational entry

3 to 10 min by hand

clinical team estimate

Same day as the miss

then after each outreach attempt

Chart · auditors · reviewers

who reads it

Appointment No-Show & Outreach Note Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Client (initials): _____ Chart #: _____ Date of entry: _____

Scheduled appointment (date / time): _____ Service type: _____

Clinician: _____ Setting (office / telehealth): _____

Attendance status

No-show · late cancellation (record when notice arrived) · clinician cancellation

Outreach attempts

One line per attempt: date · time · method (phone / text / portal / letter) · outcome

Risk review (required when the chart carries risk flags)

Risk flags · same-day outreach for flagged clients · safety plan or emergency contact activated · clinical rationale

Billing / fee decision

No claim to any payer (non-service) · client fee per written policy: applies / waived · amount

Next step (owner and date)

Reschedule date · attendance letter · welfare check · termination process with notice and referrals documented

Recorded by (front desk / clinician): _____ Date / time: _____

Clinician signature / credentials: _____ Date signed: _____