Cancellation and Financial Policy

GASTROENTEROLOGY ASSOCIATES

Canceling/Rescheduling Appointments and Procedures

We understand that sometimes it may be necessary to reschedule an appointment or procedure due to unforeseen circumstances. If you need to cancel or reschedule your appointment, we respectfully request appropriate notice (time periods provided below) to ensure appointment and procedure slots can be offered to other patients in a timely manner. Please understand that appointment and procedure times are limited.

- Cancellations less than **(7) days** before your procedure date will result in a **$100 fee**.
- Cancellations less than **(48) hours** before your procedure date/time, or **no showing** your procedure appointment, will result in a **$250 fee**.
- Rescheduling a procedure more than **(2) times** will result in a **$100 fee**, and you will be required to be seen in the office before rescheduling a 3rd time.
- Cancellations less than **(24) hours** before your office appointment date/time, or **no showing** your office appointment, will result in a **$25 fee**.
- These cancellation and no-show fees will not be applied toward your office visit/procedure and will be added as a charge to your account that is not billed to insurance.
- If the procedure or office visit is canceled by our practice, there will be no fees charged to the patient.
- Chronic cancellations or no-shows may result in dismissal from our medical practice.

It is important that when you schedule an appointment or procedure you have thoroughly checked your personal calendar to make sure that date is ideal for you. Our medical providers accommodate the needs of patients during office and procedure appointments which requires careful planning and coordinating among our office, providers, and other medical specialists such as Certified Registered Nurse Anesthetists (CRNAs).

Financial Obligations:

1. I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for insurance/medical purposes. I hereby authorize payment from my insurance company to Gastroenterology Associates, PA.
2. I am responsible for obtaining any necessary referrals and/or authorizations prior to my appointment.
3. If I do not have valid medical insurance, I am financially responsible for all fees at the time services are rendered.
4. I am expected to pay all copays, coinsurance, and deductibles at time of service.
5. I will be charged $30 for any check returned by my bank for any reason.
6. It is my responsibility to inform Gastroenterology Associates if my insurance has changed.

By signing below, I acknowledge that I understand the above cancellation guidelines and the following:

X _____ _____

Signature of Patient/Authorized Representative | Today's Date

_____ _____

Print Name | Patient Date of Birth

Thank you for providing our office and our patients with this courtesy.

MRN #_____*(office use only)*