Cancellation and Financial Policy

Patient Name: _____ **DOB:** _____

Canceling/Rescheduling Appointments and Procedures

Procedure Policy

- Cancellations less than **(7) days** before your procedure date will result in a **$100 fee**.
- **No-showing** procedure appointments will result in a **$250 fee**.
- Multiple rescheduled appts **(more than 2 times)** will result in a **$100 fee**. An office visit will also be required prior to rescheduling a 3rd time.

Office Visit Policy

- Cancellations less than **(24) hours** before, or **no-showing**, your office appointment date/time, will result in a **$25 fee**.

Our medical providers want to accommodate the needs of patients. This requires careful planning and coordination among our office, providers, and other medical specialists such as Certified Registered Nurse Anesthetists (CRNAs). It is important to review your calendar to ensure appointment dates/times are ideal for you. We understand that sometimes it may be necessary to reschedule due to unforeseen circumstances. If you need to cancel or reschedule your appointment, we respectfully request appropriate notice so appointments can be offered to other patients in a timely manner. Chronic cancellations or no-shows may result in dismissal from our medical practice.

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.

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

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

MRN #_____*(office use only)*