Associates in Gastroenterology, S.C.
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Communication

Associates in Gastroenterology, S.C. is concerned with your right to privacy. We want to ensure the secure and private communication of your protected health information. In order for us to communicate your private health and account information in a manner acceptable to you, we ask that you list your communication preferences for us (i.e. home phone, mobile phone, postal mail, etc). **A detailed message could include information related to your personal health, treatment or payment for treatment including, but not limited to, appointments, test results, diagnosis, insurance coverage and payments.**

	Preferred Method of Communication	OK to leave detailed message (please circle)
1.	_____	Yes No
2.	_____	Yes No
3.	_____	Yes No

If you would like to authorize us to share your private health or account information (the same information that is defined above) with anyone other than yourself, please list their name and their relationship to you below.

	Name:	Relationship:
1.	_____	
2.	_____	
3.	_____	

Appointments/No Show Policy

When you schedule an appointment with one of our providers, that time is reserved exclusively for you to discuss and review your medical concerns. We do understand that on occasion unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary. If you know that you will be unable to keep your appointment, we ask you to show consideration by calling our office at least 24 hours in advance for an office visit and 36 hours in advance of a procedure. Providing our office with adequate notice will allow us to offer that appointment time to another patient who needs to see the physician.

The following no show and/or late cancellation fees will be assessed for routine appointments:

1. First No Show/Late Cancellation: No Charge
2. Second No Show/Late Cancellation: $25.00 Charge
3. Third No Show/Late Cancellation: $50.00 Charge and discharge from care

The following no show and/or late cancellation fee will be assessed for failing to give at least a 36 hour notice of need to cancel a scheduled procedure: $100.00

****These charges are not billable to your insurance and will ultimately be the responsibility of the patient. All no show/late cancellation charges will need to be paid before your next appointment with the physician****

I have read and understand the above policies

_____ Date:_____
Signature

Printed Name: _____ Relationship to Patient: _____