Columbia Gastroenterology Associates, PA
No-Show Policy

All patients are required to contact the office 24 hours prior to their scheduled appointment if they are unable to keep their appointment. This allows us to see patients that otherwise would not have been able to schedule an appointment. If you do not cancel 24 hours in advance you may be subject to a no-show/ same day cancellation fee.

24 hours notification equates to 24 business hours.

Our automated system will attempt to call the contact number we have on file for you prior to your scheduled appointment. Please note this is a courtesy call only. If we are unable to reach you, this does not relieve you of the responsibility of keeping the appointment you scheduled. It is the patient's responsibility to communicate to the office any changes in address, telephone number, email address and insurance information that we need to maintain on file.

The policy for no-show or same day cancellations are as follows:

New Patients:
First
Occurrence: The first occurrence will be handled by contacting the patient via telephone and informing them of the missed appointment. The patient may reschedule the appointment with a $100.00 credit card deposit. If the patient no shows or cancels their second appointment without a 24 hour notice, the $100.00 will be nonrefundable.

Second
Occurrence: The second occurrence results in the patient losing their $100.00 deposit and no longer being rescheduled with the practice.

Established Patients:
First
Occurrence: The first occurrence will be handled by contacting the patient via telephone and informing of the missed appointment and attempting to reschedule.

Second
Occurrence: The second occurrence will be handled by contacting the patient via telephone and informing them of the missed appointment and attempting to reschedule. A $35.00 no show fee will be assessed and billed to the patient.

Third
Occurrence: The third occurrence may be handled by contacting the patient via certified mail of their dismissal from the practice. A $35.00 no show will be assessed and billed to the patient.
By signing this cancellation policy you acknowledge you have read and understand the cancellation policy.

___________________________/___________________________ ____________
Signature Printed Name Date