

No Show/Cancellation Policy

Effective July 23rd, 2008

This policy is created to increase our ability to respectfully care for all patients in a professional and timely manner, by offering open appointments times to patients who are in need.

Patient Requirements:

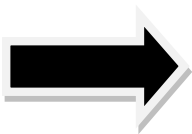
Patients unable to make their scheduled appointment are required to notify our office by calling 816-836-2200, as follows:

- **72 hour** notice if unable to keep a scheduled procedure or infusion appointment,
- **24 hour** notice if unable to keep a scheduled office visit,
- **3:00 pm on the Friday** prior to a Monday scheduled office visit, and
- **9:00 am on the Thursday** prior to scheduled Monday procedure or infusion.

Patients are responsible for maintaining current personal contact and insurance information with our office. Please review this information on each visit. Outdated patient information is the number one reason insurance companies deny claims. Denied claims are due and payable immediately from the patient.

Midwest GI Partners Guidelines:

- We make reasonable efforts to confirm scheduled appointments, however, patients are responsible for the times they have chosen whether they receive a reminder or not.
- Our practice maintains a Medicare No Show/Cancellation charge policy available for patient review, upon request.
- Appointments not canceled by the policy guidelines above, are billed as follows:
 - **\$25.00 for an office visit.**
 - **\$100.00 for procedure or infusion.**
 - **Insurance companies do not pay cancellation fees.**
 - **Patients are not rescheduled until No Show fees are paid.**



PLEASE listen carefully to all messages and/or return all calls from our office or facility promptly. If we do not receive a confirmation from you within the time frames noted above, your appointment or procedure will be cancelled.

If you confirm and do not come to the appointment, you will be charged the 'No Show' fee. No exceptions.

The best way to reach me is: _____

I have read and understood the above policy and agree to abide by the guidelines as outlined, pay any fees I incur; and any additional fees incurred in the attempt to collect unpaid debts.

Patient Signature

Date

Printed Patient Name

DOB