Nuclear Stress Test, Echocardiogram Test And Office Visit Cancellation "No Show" Policy Agreement

We expect that our patients will keep their appointments, which are setup with mutual agreement. There are always several patients, who would like to be treated sooner, but have to wait for their turn, as this office is very busy.

When a patient does not show up for his/her appointment or does not give adequate cancellation notice, that time slot is wasted, which could have been utilized to take care of other patients, especially for those who would like to get in sooner. Besides, the office has to order the expensive radio-nucleotide used for the test in advance from a specialty pharmacy. This medication is time sensitive with a short shelf life therefore cannot be returned or utilized for a different patient.

Please also note that not showing up for a mutually scheduled test is also considered your refusal to follow your doctor's recommended treatment plan and that may not be best for your health.

This office reserves the right to bill the patients a **"NO SHOW FEE"** for not showing up or giving adequate notice of cancellation **(24 HOURS)** . The **"NO SHOW FEE'S"** are **Nuclear Stress Test $320.00(For TST please see your protocol sheet for food and caffeine restrictions). Echocardiogram Test $125.00. Office Visit $50.00.** Please note that your insurance company will NOT pay this amount and you will be personally responsible for the fee. We may or may not reschedule your appointment until this fee is paid and we may take all necessary steps to collect this amount, including use of a collection agency. Certainly, we will use discretion while implementing this policy as we realize that true emergencies do occur.

AGREEMENT

I, ________________________ have read and understand the above "Nuclear Stress Test/Echocardiogram Appointment Cancelations and NO SHOW Policy". I agree Dr. Chandramouli reserves the right to bill me Three Hundred Twenty Dollars ($320.00) for not showing up at my scheduled appointment, or for not giving adequate notice of 24 hours for cancellation. I further agree that I will be personally responsible for this charge and I may not be rescheduled if I do not pay the "NO-SHOW" charge billed to me.

________________________________ ________________________________

Signature Date

Witness: ____

We will call in advance to confirm appointment to number provided________________

Phone Number

BV Chandramouli MD 530-244-4471