DRS. GIRGIS & ASSOCIATES
Breathe Better, Hear Better, Sleep Better

CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Drs. Girgis and Associates. When you schedule an appointment with us, we set aside time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Cancellation/No Show Policy below:

Effective January 1, 2023

- Any established patient who fails to show or cancels/reschedules an office visit appointment and has not contacted our office with **at least 1 business day notice** will be considered a No Show and charged a **$50.00 fee**.

- Any patient who fails to show or cancels/reschedules an in-office procedure or testing including but not limited to **In-Lab Sleep Studies, Sinus Procedures, and VNGs** and has not contacted our office with **at least 2 business days notice** will be considered a No Show and charged a **$250 fee**.

- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.

- If a third No Show or cancellation/reschedule without sufficient notice should occur the patient may be dismissed from the practice.

- Any new patient who fails to show for their initial visit will not be rescheduled without approval from the practice administrator.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Billing Manager, who may be able to waive the No Show fee. You may contact Drs. Girgis and Associates at the number below. Should it be after regular business hours you may leave a message with our answering service.

Drs. Girgis and Associates (630) 323-5214

I have read and understand the Cancellation/No Show Policy and agree to its terms.

_____   _____
Signature of Patient or Legal Guardian   Relationship to Patient

_____   _____
Printed Patient's Name   Date

_____
Patient's Date of Birth

MRN:_____
(Internal Office Use Only)