MITTAL
Gastroenterology & Rheumatology

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Notice to Our Patients regarding Office Policies

Thank you for your confidence in our practice and we appreciate your continued support. We have implemented an office policy to aid us in your visit to our office and our procedure centers.

INSURANCE: While our office can offer some guidance regarding insurance coverage, it is ultimately **your** responsibility to ensure that any tests, procedures, infusions, medication and professional referrals are covered by your insurance plan.

APPOINTMENTS/PROCEDURES: To allow our office to provide quality care and efficient service, we request that you cancel any appointments that you cannot keep at least 24 hours prior to your scheduled visit. This allows patients who require immediate care to have that appointment time. Failure to notify our office within that time frame will result in a $50.00 missed appointment fee. **Failure to cancel your procedure within 72 hours (3 business days) prior to your procedure date will result in a $150.00 fee.** Please call (559) 900-4013 to cancel appointments or procedures. We understand that situations such as emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis. If you reach us after normal business hours, please leave a message with our answering service.

LATE POLICY: We make every effort to be on time for all our appointments. **Patients arriving more than 10 minutes after their appointment time will be asked to either be seen in a later available timeslot or reschedule their appointment.** We apologize for any inconvenience this might cause.

PRESCRIPTIONS: There is a 48-hour (2 business days) turnaround time for all prescription refill requests. If you are traveling or need to refill a prescription prior to the weekend, please call our office ahead of time to allow us to process your request accordingly.

By signing below I agree that I have read and understand the items listed above and agree to all terms and conditions listed in the Mittal Gastroenterology & Rheumatology Office Policy.

Patient Name:_____ Date: _____

Patient Signature: _____