

Acknowledgement of Receipt of Notice of Privacy Practices & Patient's Right and Responsibilities

I, _____ acknowledge that I have received a copy of Gastroenterology Associates, P.C./Endoscopy Center for Digestive Health Notice of Privacy Practices. This Notice describes how Gastroenterology Associates, P.C./Endoscopy Center for Digestive Health may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

I also acknowledge that I have been offered a copy of the Patient's Rights and Responsibilities brochure.

May our office leave a message on your answering machine or with a family member?

IE: Test results; messages from the doctor, etc. YES NO

Name and phone number of the person(s) we may speak with regarding your health:

_____	_____
_____	_____
_____	_____

Acknowledgement of No Show Charge Policy

As a courtesy to other patients who wish to see the doctor as quickly as possible, please call to reschedule or cancel your appointment as soon as possible. If you contact our office more than 24 hours before an office visit and at least three business days before a procedure you will avoid the No Show charge.

If you do not call to cancel your appointment more than 24 hours before an office visit or at least three business days before a procedure you will be billed \$25 for a missed office visit or \$75 for a missed procedure. Our goal is provide excellent care to our patients, the No Show charge helps us ensure efficient and effective scheduling so that patients may be seen by their doctor as quickly as possible.

Signature of Patient or Personal Representative

Date _____

Relationship to Patient

**Gastroenterology Associates P.C.
Endoscopy Center for Digestive Health**