

Houston Gastrointestinal & Liver Clinic, P.A.
17510 W. Grand Parkway, Suite 410, Sugar Land, TX 77063
16659 Southwest Fwy, Suite 215, Sugar Land, TX 77479

Sreelatha Reddy, M.D.
Phone: (713) 773-1800
Fax: (713) 773-1809

Cancellation Policy Form

Patient Name: _____ Date of Birth: _____ MRN: _____

Dear Valued Patient,

We are reserving a time for your office visit appointment and/or procedure. If you are scheduled for a procedure, it is important that you arrive on time and be prepared to have your procedure done on the day and time of your reservation.

Since we have a limited number of appointment times to reserve for our patients to have their procedures performed, we need to assure that your appointment is kept. Should you find you are unable to keep your office visit/procedure appointment, please let us know at least 72 hours in advance so another patient may be scheduled in your place.

If you are not able to keep your appointment and do not let us know in advance of 72 hours of your reservation, then effective immediately, there will be a fee of \$50 billed to your account as a missed office visit/procedure fee. This fee will be your responsibility and will not be billed to your insurance.

Thank you for your understanding and assistance in assuring your care is provided timely and as scheduled. I appreciate the opportunity to be a part of your medical care team.

Sincerely,
Houston Gastrointestinal & Liver Clinic, P.A.

I acknowledge that I will be responsible for payment of the missed procedure fee that will be charged in the event I do not keep my procedure appointment and do not notify the office at least 72 hours in advance. I understand this is a missed appointment fee and as it is my financial responsibility, it will not be billed to my insurance on my behalf.

Patient Signature: _____ Date: _____

PLEASE COMPLETE ALL PAGES