Gastrointestinal Institute, LLC
Illinois Gastroenterology, Ltd
a member of Premier Medical Group, LLC
2200 Jacobssen Drive
Normal, IL 61761

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CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide ample notice. This will make it possible for another patient who is waiting for an appointment to be scheduled in that appointment time. When cancellations are made without ample notice, we are unable to offer that reserved time to other patients.

Premier Medical Group, LLC Appointments:
Any appointments canceled without at a minimum of 24 hours notification may be charged for a **CANCELLATION FEE** of **$50.00**. Patients who do not show up for their appointment without a call to cancel will be considered as **NO-SHOW** and charged **$50.00**. Patients who **No-Show** two (2) or more times in a 12 month period, may be dismissed from the practice and may be denied any future appointments.

Gastrointestinal Institute, LLC Procedure Appointments:
Any procedure appointments regardless of the facility where the procedure will be serviced canceled without at a minimum of **72 hours notification (3 business days)** may be charged for a **CANCELLATION FEE** of **$150.00**. Patients who do not show up for their procedure appointment without a call to cancel will be considered as **NO-SHOW** and charged **$150.00**. Patients who **NO-SHOW** may be required to schedule another office visit prior to rescheduling any procedure. Patients who **No-Show** two (2) or more times in a 12 month period, may be dismissed from the practice and may be denied any future appointments.

The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department at (309) 451-1123

YOUR SIGNATURE INDICATES THAT YOU HAVE READ, UNDERSTOOD AND HAVE AGREED TO FOLLOW THIS CANCELLATION AND NO SHOW POLICYS.

_____ Date of Birth: _____
Patient Name **(Please print)**

_____ Date: _____
Signature of Patient or Patient Representative

This authorization will remain in effect until revoked by patient.

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