

# #3

Associates in Internal Medicine, P.C.  
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## No Show Policy, Fees and Surcharge Fees for Late Payments

### POLICY MUST BE SIGNED IN ORDER TO BE A PATIENT OF ASSOCIATES IN INTERNAL MEDICINE, P.C.

Dear Patient,

Please be advised that we require no less than 24 hours notice whenever an appointment is cancelled. However, if you have an appointment on a Monday before 12:00pm, you must call **before 12:00pm the Friday prior** to your scheduled appointment or you will be billed a No-Show Fee. Insurance plans are not responsible for No Show Fee's; it is the responsibility of the patient to pay the bill upon receipt. If you need to cancel an appointment and it is after hours or during the weekend, you may leave a message with our service. We recommend that you make note of the name of the service operator and/or receptionist whenever you call to cancel an appointment.

### Fee Schedule for No Show Fees:

- 1<sup>st</sup> No Show for a Follow Up Visit - \$25
- 2<sup>nd</sup> No Show for a Follow Up Visit - \$30
- 3<sup>rd</sup> No Show for a Follow Up Visit - \$35
  
- No Show for an Establish Patient Physical or New Patient Visit is \$75.00
  
- All Types of Saturday Appointments - \$100.00
- Echo Appointments - \$75.00
- Bone Density - \$35.00
- Blood Pressure - \$50
  
- **IF A PATIENT IS A NO SHOW 3 TIMES, THEY WILL BE DISENROLLED FROM THE PRACTICE. MEDICAL RECORDS WILL BE FORWARDED ONCE THE PATIENT SELECTS A NEW PRIMARY CARE PHYSICIAN. THERE ARE NO EXCEPTIONS TO THIS RULE. WE MUST HAVE AN ACCURATE SCHEDULE IN ORDER TO SERVICE ALL PATIENTS NEEDS AND NO SHOWS MAKE IT DIFFICULT TO DO SO.**

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Also, all payments and co-payments are due at " Point of Service ". We take credit cards, checks and cash for patient's convenience. If payment is not received at the time of your visit, a surcharge is added. Presently the surcharge is \$5.00, but is subject to change.

Patients are required to present their current insurance card every time they see the physician or have a lab appointment.

\_\_\_\_\_  
(PRINT PATIENTS FIRST AND LAST NAME)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(Patients Signature)

\_\_\_\_\_  
(DATE)

