Nuclear Stress Test Cancellation Policy: Alpharetta Internal Medicine

Patient name: _____ App date & time: _____

I understand that if my test needs to be rescheduled or cancelled for any reason, the office needs to be notified 3 business days prior to my appointment. I will be charged a **$175.00** missed appointment fee if I do not give a notice in the allotted time frame. I also understand that it is my responsibility to check my insurance benefits as to what is covered under my insurance plan regarding the above scheduled test. I will be responsible for the amount due that my insurance does not cover.

_____ _____

Patient Signature Date