"NO-SHOW" APPOINTMENT POLICY

Effective August 1, 2018, revised August 21, 2019

Dr. Alexandridis understands that sometimes you need to cancel or reschedule your office appointment or hospital procedure due to emergencies. If you are unable to keep your appointment, please call us *as soon as possible*. You can reschedule appointments by calling (707)938-7690 or by visiting www.dralexissurgery.com and going to the *Contact* page. There is often a waiting list to see Dr. Alexandridis and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit *on time*. As a courtesy, an appointment reminder call to you is made/attempted two business days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for the appointment on time. **For new patients, we ask that you complete your medical history questionnaire in advance, or arrive 10-15 minutes ahead of your appointment time so that you may complete this questionnaire.** Late arrivals can be very disruptive to the doctor's office and operating schedules, not to mention the schedules of other patients.

PLEASE REVIEW THE FOLLOWING POLICY:

1. We require at least **24-hours**' notice:
    a. If less than a 24-hour cancellation is given, this will be considered a "No-Show" appointment.
    b. If you do not present to the office for your appointment, this will be considered a "No-Show" appointment.
2. "No-Show" appointments in the office will be assessed a **$25 fee**, and this is ***not*** covered by insurance/Medicare/Medi-Cal. **This will be collected prior to rescheduling the appointment.** Three "No-Shows" will require a new referral prior to being seen by the surgeon.
3. Please reschedule operations/procedures with at least **3 business days**' notice by calling our office (*not* the hospital). A **$25 fee** will be assessed for canceled or "No-show" operations/procedures. This is ***not*** covered by insurance/Medicare/Medi-Cal. **This will be collected prior to rescheduling the operation/procedure.**
4. Late arrivals to appointments (over 15 minutes) will be rescheduled. Late arrivals to the hospital will be rescheduled at the discretion of the operating room staff.

I have read and understand Dr. Alexandridis' "No-Show" Appointment Policy and understand my responsibility to plan appointments accordingly and notify the office appropriately if I have difficulty keeping my scheduled appointments.

_____	_____	_____
Patient Name	Date of Birth	Today's Date
_____	_____	
Patient Signature or Parent/Guardian if minor	Relationship to Patient	

Alexis Alexandridis M.D.
BREAST & GENERAL SURGERY

Patient's Name (printed)

BILLING AND COLLECTIONS POLICY

I understand that I (or, the responsible party listed on my account) will be obligated to pay for all rendered services that my insurance/health plan deem "patient responsibility". I also agree to submit my co-pay or co-insurance at the time of service. If there is a balance on my account, I must make payment plan arrangements or submit payment in full before further services are rendered. I understand I may be turned over to a debt collections agency for non-payment of past-due balances. I understand that all major credit cards, cash, and check methods of payment are accepted.

By signing below, I agree that I have reviewed and understand the information above.

Signature Today's Date Relationship to Patient

PRIVACY AND PROTECTED HEALTH INFORMATION

I understand that Alexis Alexandridis MD Inc. will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written, electronic or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Alexis Alexandridis MD Inc. may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, as well as submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that the practice is not required by law to agree to such requests.

I also understand that I have the right to receive and review a written description of how the practice will handle health information about me. This written description, known as a Notice of Privacy Practices, describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel, and my rights regarding my health information.

I further understand that it is the policy of Alexis Alexandridis MD Inc. to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how the practice will (1) identify, (2) detect, and (3) respond to "red flags" which are defined by this policy as including a pattern, practice, or specific account or record activity that indicates possible identity theft. I understand that the Notice of Privacy Practices is available to me upon request and that it is the policy of Alexis Alexandridis MD Inc. to review and update these policies no less than annually, of which I may have a copy of the updates upon request.

By signing below, I agree that I have reviewed and understand the information above.

Signature Today's Date Relationship to Patient