

Fresno

Gastroenterology

A Member of Community Foundation Medical Group & Part of Santé Health Foundation

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7055 N Maple #106
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Ph. 559-297-2259
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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that I may ask for a copy of this or any amended Notice of Privacy practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

Cancellation Policy

Effective October 1, 2010

As a courtesy to other patients, please notify us if you are unable to keep your appointment.

You may be charged a cancellation fee of \$75.00 if you fail to cancel within 3 business days of a procedure related appointment, and \$50.00 for an office appointment. Your insurance may not cover this fee.

Signed: _____ Date: _____

Race: Asian/A Asian Pacific/F African-American/B Caucasian/C
 Hispanic/H Alaskan/I Native American/G Other/E

Ethnicity: Latino/Hispanic/L Other/O Not Reported/Refused/N

Language: _____