IMPORTANT NOTICE

IT IS POSSIBLE THAT YOUR TREATMENT WILL INCLUDE AN OUTPATIENT PROCEDURE. PLEASE BE AWARE THAT THERE MAY BE CHARGES SEPARATE FROM DR. RIDDICK'S FEE. I.E., HOSPITAL, ANESTHESIA, PATHOLOGY.

IF YOU HAVE A PROCEDURE THAT IS SCHEDULED AT GEORGIA ENDOSCOPY CENTER THAT NEEDS TO BE CANCELLED, A 4-DAY NOTICE IS REQUIRED. IF THE APPROPRIATE NOTICE IS NOT RECEIVED, A FEE OF $100.00 WILL BE CHARGED TO THE PATIENT. INSURANCE COMPANIES WILL NOT COVER THIS FEE. WE ALSO REQUIRE A 24 HR NOTICE FOR OFFICE VISIT CANCELLATION. A $25 FEE WILL BE CHARGED. (EXCEPTION: ILLNESS OR DEATH IN THE FAMILY)

THERE MAY ALSO BE TIMES WHEN OUR DOCTOR NEEDS TO ORDER TESTING OUTSIDE OF OUR OFFICE, WHICH MAY INCLUDE BLOOD WORK, X-RAYS, ETC. THESE CHARGES ARE NOT PART OF THE OFFICE VISIT AND YOUR REGULAR BENEFITS WILL APPLY.

IF YOU ARE HERE FOR A CONSULTATION VISIT PRIOR TO SCHEDULING A COLONOSCOPY, PLEASE BE ADVISED THAT THIS IS CONSIDERED A SPECIALIST OFFICE VISIT AND NOT CONSIDERED PREVENTATIVE. YOUR USUAL BENEFITS WILL APPLY AS WITH ANY OTHER SPECIALIST OFFICE VISIT.

IF YOUR INSURANCE REQUIRES A REFERRAL TO OUR OFFICE, IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN. IF A PROCEDURE YOU HAVE SCHEDULED NEEDS TO HAVE PRECERTIFICATION, OUR OFFICE WILL OBTAIN THIS FROM YOUR INSURANCE COMPANY.

IT IS THE PATIENT'S RESPONSIBILITY TO KNOW WHAT HIS/HER INSURANCE BENEFITS ARE AND WHAT THEY WILL OR WILL NOT COVER.

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE.

PATIENT'S SIGNATURE **Date**