AMBRAD-CHALELA
VASCULAR SURGERY & ULTRASOUND LAB

TRI-CITIES VEIN & VASCULAR INSTITUTE
Esteban Ambrad-Chalela, MD

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(509) 946-9707
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Cancellation & No-Show Policy

General Information: To help our patients, we will call to confirm your appointment one day before your scheduled appointment. We understand that sometimes you need to cancel or reschedule your appointment. If you cannot come to your appointment on the scheduled day and time, you need to call to cancel the appointment as soon as possible. By cancelling your appointment as soon as possible we can help patients who are waiting to be seen.

How Do I Cancel My Appointment? Please call our office at **509-946-9707**. If you get our voicemail, please do not hang up. Leave the following information:

- Your name and phone number
- The reason you are cancelling your appointment
- The date and time of your appointment

What Happens If I Miss My Appointment and Do Not Call to Cancel?

- We enforce a "No-Show Policy". We feel this policy is important because no-show visits keep other patients from being seen in our office.
- If you do not call to cancel your appointment ahead of time it will be considered a "No-Show Visit". Every no-show visit will be recorded in your file.
- Multiple no-show visits can end your ability to receive health care services in our office.

As a patient of Esteban Ambrad-Chalela, MD you are asked to make all reasonable attempts to your keep your scheduled appointment. If you need to cancel an appointment we ask that you call as soon as possible.

Our No-Show Policy Is: First "NO SHOW" — you will receive a "NO-SHOW" fee of $50. You will be able to continue receiving services at our office.

Second "NO SHOW" — you will receive a NO-SHOW FEE in the amount of $100
We reserve the right to cancel our patient/physician relationship at this time.

Records Fee:	$30	Laser Ablation	$1,000	Vein Gogh	$100
Forms Fee:	$25	Phlebectomy	$500	Surgery @ KRMC	$1,000
Returned Check	$35	Sclerotherapy	$100	Office Visit	$ 50-100

I understand the No-Show Policy and I agree to follow the policy. Date: _____

Patient Name : _____ (Please Print)

Patient Signature: _____