

# H. ALAN SCHNALL, M.D.

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DIPLOMATE, AMERICAN BOARD  
OF GASTROENTEROLOGY

GASTROENTEROLOGY  
GASTROINTESTINAL ENDOSCOPY

## ENDOSCOPY PROCEDURE AND CANCELLATION POLICY

I will be performing your procedure at Queens Endoscopy, a state-of-the-art Ambulatory Surgery Center in Queens, where I am able to provide the highest quality medical care. At the center we have a wonderful and courteous staff, we are utilizing the best instruments available with the highest level of quality and infection control, and we are carefully regulated and certified/credentialed by the NY State Department of Health.

Queens Endoscopy participates in-network with most insurance plans. You are responsible for any co-payments and deductibles as per your own health insurance policy; we encourage you to contact your insurance company to verify your financial responsibilities. Queens Endoscopy makes every effort to contact your insurance carrier to obtain that information as well, and to call you within several days of your scheduled procedure to notify you of your financial obligations to the Surgery Center.

**\*\*\*If you do not hear from Queens Endoscopy within 2-3 days of your procedure, please call their Benefits Department at (833) 815-0637, and they will be able to supply you with your financial obligation.\*\*\***

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Please remember that in order to accommodate another patient in your place we must notify the patient at least 5 days prior to the procedure to make arrangements and prepare for his/her surgery.

### Cancellation/No Show Policy for Surgery:

Due to the large block time needed for surgery, last minute cancellation can cause problems and added expenses for the office and/or facility.

If the surgery is not cancelled at least 5 days in advance, you will be charged seventy-five dollars (\$75.00) fee; this will not be covered by your Insurance.

\_\_\_\_\_  
Print Name (Patient)

\_\_\_\_\_  
Signature Patient/Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Patient Account# \_\_\_\_\_