



**Turkey Creek Office**

11440 Parkside Drive  
Suite 302  
Knoxville, TN 37934  
Ph. (865) 218-9220  
Fx. (865) 218-3331

**Cherokee Mills Office**

2250 Sutherland Avenue  
Suite 121  
Knoxville, TN 37919  
Ph. (865) 218-9220  
Fx. (865)218-3330

Welcome \_\_\_\_\_

Your Appointment is \_\_\_\_\_ Location \_\_\_\_\_  
(Date and Time)

Thank you for choosing our practice for your medical care. The staff of Faculty Internal Medicine wants to make your experience with our office pleasurable.

For your convenience, below is a check list of what you need to bring to your first appointment:

- Patient History Record (included in this packet)**
- Complete medication list**
- Photo ID**
- Insurance Card/s**
  - Policy holders address and date of birth for each**
- Co Pay and/or coinsurance**
- Names and phone numbers of anyone allowed to have access to your medical and/or financial records**
- Names and phone numbers of all emergency contacts**
- Living Will**

We do ask that you arrive **30 minutes** prior to your appointment. This will allow time for you to input this information into our electronic check-in system. This system is an electronic tablet where information is gathered from the patient and electronically transmitted into your medical record, eliminating the need for paper.

We ask that you present this packet fully completed at your time of arrival. Failure to have this packet filled out completely may result in your appointment being rescheduled.

We ask that you come to your New Patient appointment **fasting** in case the physician orders lab work:

**AM appointments:** Nothing to eat or drink after midnight. You may have water or black coffee.

**PM appointments:** You may have a light non-fat breakfast 8 hours prior to your scheduled appointment. You may have water or black coffee.

Faculty Internal Medicine staff can not assist you from your vehicle into our suite or from our suite to your vehicle. We do have wheelchairs in our suite that you may utilize at your visit. If you need assistance with navigation, please have a caregiver accompany you to your scheduled appointments.

We want to make your experiences in our office positive ones. Please alert us to any special needs, questions or concerns. If there is ever anything we can do to improve your experience in our office, please let us know.

Thank you for allowing us to serve you! We look forward to seeing you soon.

Sincerely,  
Faculty Internal Medicine

# Faculty Internal Medicine

## Patient Information Sheet

### After-hours EMERGENCIES:

- In case of a major emergency, call 911 or proceed to the nearest emergency room. If necessary, the emergency room will contact the physician.
- For other after-hours problems that require a doctor (weekends, holidays or week days 4:00 PM – 8:00 AM) our telephone number is 865-218-9220. The physician or his representative will return your call.
- All after hours phone calls are subject to a \$25.00 fee. Most insurance companies will not cover this fee therefore; we will not file with your insurance company. You will be responsible to pay this fee.
- Prescription refills are handled only during office hours to maintain quality of care and reduce prescribing errors.

### What to bring to the office each visit:

- Current health insurance card
- Means of paying for services or co-payments
- Photo identification
- Any change of address, phone number, employment
- List of all medication including occasional medication, 'over the counter' medication or supplements (vitamins, herbs, etc.). Please include dosages, and how often taken.

### Appointments:

- When you schedule your appointment, please provide the complete list of reasons for your appointment so that we can schedule an appropriate amount of time for your appointment. If you are coming for an annual/physical exam, but have other medical issues for the doctor to review, please inform us when scheduling the appointment. To keep your waiting time to a minimum, we need to know how much time to schedule for whatever issues you may need to discuss with the doctor.
- Please provide at least 24 hours notice if it becomes necessary for you to cancel or reschedule an appointment.
- Faculty Internal Medicine staff can not assist you from your vehicle into our suite or from our suite to your vehicle. We do have wheelchairs in our suite that you may utilize at your visit. If you need assistance with navigation, please have a caregiver accompany you to your scheduled appointments.

### Phone calls during business hours:

- While the physicians or the nurses are seeing patients, a "triage nurse" is on duty to handle medical calls. However, if the triage nurse is assisting another patient at the time of your call, you may be asked to leave a message on the voicemail and the nurse will return your call as soon as possible.
- It is our office policy that if the patient is ill enough to require a prescription for an antibiotic, he/she will need to schedule an appointment for an office visit within a reasonable time period. Antibiotics will not be prescribed over the phone without an office visit being scheduled within a day or two.
- When leaving a message please state the reason for your call, your name, your date of birth and your phone number. Please also spell your last name and repeat your phone number slowly. This will allow a nurse to accurately document your problem for better quality of care.
- If your message is not clear and understandable on the voicemail, we will not be able to respond to your requests.
- Routine Calls – expect a return phone call by the end of the same business day, but on occasion there may be a delay until the following business day.
- Urgent Medical Calls – will be returned as promptly as possible and may require phone triage as we handle hundreds of messages each day. If you cannot wait for a return call, urgent care clinics or various emergency rooms are available.

### Prescription Refills:

- Please call your pharmacy at least THREE (3) business days before you need your refill. The pharmacist will notify our office for approval of refills. To provide the best patient care, our office may limit or not authorize refills if we have not seen you in the office in an appropriate time period.
- If you need a prescription for your mail-order pharmacy, please notify us at the time of your appointment.

### Your Insurance:

- Please be familiar with your insurance benefits. If you expect insurance to pay for your services, please be sure that our office is a provider on your insurance plan. Also, please notify the office whether your plan covers preventive medicine or wellness care (physicals), and what the limitations of this coverage are. Also, if you want to have multiple procedures done on the same visit, please check with your insurance company to see if they will cover multiple procedures on the same day. Many insurance companies



## Patient Registration

*Please have this information available to input in our electronic check-in system.*

**Patient information:**

NAME (last, first, middle): \_\_\_\_\_ TITLE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

PREFERRED NAME: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ SEX: M \_\_\_ F \_\_\_

EMPLOYER/ADDRESS: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

WHOM MAY WE THANK FOR THIS REFERRAL? \_\_\_\_\_

**PRIMARY Insurance:** \_\_\_\_\_  
(Please present your insurance card to our front office staff to be copied)

Policyholder Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policyholder Address: \_\_\_\_\_

Employer: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SECONDARY Insurance:** \_\_\_\_\_  
(Please present your insurance card to our front office staff to be copied)

Policyholder Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policyholder Address: \_\_\_\_\_

Employer: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

***You will be required to sign our Financial Policy on the electronic check-in system.***

## ***Financial Policy***

Please note that all insurance providers have different coverage and benefit levels depending on what you have chosen to purchase or what your employer has chosen for you. Some plans require that you pay a deductible for labs and diagnostic testing in addition to your visit copay. You should check with your insurance provider to see what your plan covers and what you will be responsible to pay for labs, x-rays and other diagnostic tests. We use outside reference labs (Labcorp, Quest, Millennium) for labs that we do not perform in our office. They are participating on most plans, however, you may be billed by them for any balance not covered by your insurance.

We participate with most insurance plans. If you are an HMO patient, you must choose one of our physicians for your primary care physician. This can be done by calling your insurance company and having them list our physician as the PCP. You will be responsible for the visit if we are not listed as the PCP with your plan.

As a courtesy, we will submit your claim for all services to your insurance company. Please remember your individual health insurance policy is a contract between you and your insurance company and we are not a party to that contract. Be aware that some of your services may not be covered by your insurance policy. By presenting for care, you agree that you are responsible for all services and charges regardless of your insurance status. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed in order that your insurance will cover the charge. You will be responsible for the balance.

All balances including deductibles and copays are due at the time of service. We file your insurance and then any balances that are due by you must be paid within 30 days unless prior arrangements are made with the billing office. If you have a billing or insurance question, please contact our billing office (865) 288-1100 and they will be happy to assist you. We ask patients to refrain from discussing billing questions with the physicians as they devote their time and expertise to your health care and cannot answer billing questions.

### **Additional Practice Related Fees:**

- \$25.00 Fee = Request to complete Life, Disability, FMLA, & various other types of independent health forms.
- \$30.00 Fee = Returned checks for non-sufficient funds will have a processing fee that will be charged back to the patient. We will be unable to accept any personal checks after the first occurrence.
- \$25.00 Fee = After hour phone calls to the physician may be charged a fee.
- \$25.00 Fee = Charge for missed appointments or appointments canceled with less than 24 hour notice with the Physician or Nurse Practitioner.
- \$50.00 Fee = Charge for missed appointments or appointments canceled with less than 24 hour notice on any testing (i.e.: ultrasounds, cardiac testing, etc.)

# MEDICATION LIST

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

**Active Medications**  
(including non prescription)

**Dose**

**Prescribing Physician**

- |           |       |       |
|-----------|-------|-------|
| 1. _____  | _____ | _____ |
| 2. _____  | _____ | _____ |
| 3. _____  | _____ | _____ |
| 4. _____  | _____ | _____ |
| 5. _____  | _____ | _____ |
| 6. _____  | _____ | _____ |
| 7. _____  | _____ | _____ |
| 8. _____  | _____ | _____ |
| 9. _____  | _____ | _____ |
| 10. _____ | _____ | _____ |
| 11. _____ | _____ | _____ |
| 12. _____ | _____ | _____ |
| 13. _____ | _____ | _____ |
| 14. _____ | _____ | _____ |

**Medication Allergies**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Updated:**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_



## PATIENT PRIVACY QUESTIONNAIRE

*Please have this information available to input in our electronic check-in system.*

### CONTACT RECORD

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

#### Please contact me as follows: (in order of preference)

1. ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Home, Work, Cell Phone, Other (circle one)
2. ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Home, Work, Cell Phone, Other (circle one)
3. ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Home, Work, Cell Phone, Other (circle one)

- Okay to leave messages with healthcare information
- Leave message with call back number only
- Do **NOT** leave messages
- No restrictions – speak with whomever necessary on my behalf

#### List the names and phone numbers of individuals you authorize us to speak with regarding your healthcare:

- None
- Spouse \_\_\_\_\_ Phone Number \_\_\_\_\_
- Child \_\_\_\_\_ Phone Number \_\_\_\_\_
- Parent \_\_\_\_\_ Phone Number \_\_\_\_\_
- Other \_\_\_\_\_ Phone Number \_\_\_\_\_

**Note:** If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address.

I have received a copy of Faculty Internal Medicine's Notice of Information Practices. I understand this Notice describes how my health information may be used or disclosed by FIM physicians and other providers at Faculty Internal Medicine. It is our policy that patient medical records will be given only to the patient unless specified otherwise above. This authorization does not expire unless revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to Faculty Internal Medicine. I am aware the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (865) 218-9220 or on the web site at [www.facultyinternalmedicine.com](http://www.facultyinternalmedicine.com) or by requesting one at the Faculty Internal Medicine office. Information that is disclosed under this au-thorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Faculty Internal Medicine discloses it to a party listed above. You may inspect or copy information used or disclosed under this authorization.

**PATIENT HISTORY RECORD  
FACULTY INTERNAL MEDICINE**

Date of Appt: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Last First Middle

**The information you provide today is very important in regards to your healthcare. Please answer the following questions carefully and thoroughly to the best of your ability.**

Reason for today's visit (list in order of importance to you): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Other physicians you are currently seeing:

\_\_\_\_\_  
\_\_\_\_\_

Do you see a Chiropractor, Massage therapist, Therapist, Faith healer, Practitioner of homeopathy and/or others?  
Please list: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY:**

Do you have or have you ever had?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Colonoscopy (Date ___/___/___) | <input type="checkbox"/> Seizures                         |
| <input type="checkbox"/> Heart disease           | <input type="checkbox"/> Anemia (low blood)             | <input type="checkbox"/> Cancer                           |
| <input type="checkbox"/> Heart attack            | <input type="checkbox"/> Blood transfusions             | <input type="checkbox"/> Breast masses                    |
| <input type="checkbox"/> High cholesterol        | <input type="checkbox"/> Bleeding disorder              | <input type="checkbox"/> Prostate disease                 |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Blood clots                    | <input type="checkbox"/> HIV screening (Date ___/___/___) |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Splenectomy                    | <input type="checkbox"/> AIDS/HIV                         |
| <input type="checkbox"/> Thyroid disease         | <input type="checkbox"/> Asthma/allergy                 | <input type="checkbox"/> DEXA (Date ___/___/___)          |
| <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Emphysema/COPD                 | <input type="checkbox"/> Arthritis                        |
| <input type="checkbox"/> Colon disease           | <input type="checkbox"/> Pneumonia or TB                | <input type="checkbox"/> Depression                       |
| <input type="checkbox"/> Stomach disease         | <input type="checkbox"/> Glaucoma                       | <input type="checkbox"/> Other _____                      |
| <input type="checkbox"/> Liver disease/hepatitis | <input type="checkbox"/> Nervous/anxiety problems       | _____   |

Patient Name: \_\_\_\_\_

**Hospitalizations:**

Please list hospitalizations and dates for medical and surgical problems including childbirth:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Please provide the last date(s) of the following:**

Pneumococcal 23:	__/__/__	Hep A vaccine:	(1 <sup>st</sup> ) __/__/__	(2 <sup>nd</sup> ) __/__/__
Pevnar 13 vaccine:	__/__/__	Hep B vaccine:	(1 <sup>st</sup> ) __/__/__	(2 <sup>nd</sup> ) __/__/__ (3 <sup>rd</sup> ) __/__/__
Flu vaccine:	__/__/__	Gardasil vaccine:	(1 <sup>st</sup> ) __/__/__	(2 <sup>nd</sup> ) __/__/__ (3 <sup>rd</sup> ) __/__/__
Tetanus vaccine:	__/__/__	Shingles vaccine:	(1 <sup>st</sup> ) __/__/__	(2 <sup>nd</sup> ) __/__/__
		MMR vaccine:	(1 <sup>st</sup> ) __/__/__	(2 <sup>nd</sup> ) __/__/__
COVID Vaccine:	(1 <sup>st</sup> ) __/__/__	(2 <sup>nd</sup> ) __/__/__	Brand:	_____

**Social History:**

Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Education (Highest level completed) \_\_\_\_\_ Marital status \_\_ (M) \_\_ (W) \_\_ (D) \_\_ (S)  
 Spouse Name \_\_\_\_\_ His/Her employer \_\_\_\_\_  
 Religious preference if any \_\_\_\_\_

**Smoking:**

Do you currently smoke? __Yes __No	Have you ever smoked? __Yes __No
Age started _____ Age stopped _____	How many packs per day? _____
Interested in stopping? __Yes __No	Dip/Snuff/Chew? __Yes __No

**Alcohol:**

Do you drink alcohol? __Yes __No	How many drinks/week? _____
Do you think you have a drinking problem?	__Yes __No
Do you feel the need to cut down?	__Yes __No

**Drugs:**

Do you presently use drugs? \_\_Yes \_\_No  
 Have you ever used drugs (eg: cocaine, marijuana, heroin)? \_\_Yes \_\_No



Patient Name: \_\_\_\_\_

**Wellness practices:**

Do you examine your skin? \_\_Yes \_\_No

Do you use sun protection? \_\_Yes \_\_No

Do you use a seat belt? \_\_Yes \_\_No

Do you currently exercise? \_\_Yes \_\_No

Type of exercise \_\_\_\_\_ Frequency and duration of exercise \_\_\_\_\_

Hobbies/recreation: \_\_\_\_\_

Have you been hurt or threatened by someone? \_\_ Yes \_\_ No

If yes, please explain: \_\_\_\_\_

**Family history:**

Father: Current age (if living) \_\_\_\_\_

Illnesses \_\_\_\_\_

Age at death \_\_\_\_\_

Cause of death \_\_\_\_\_

Mother: Current age (if living) \_\_\_\_\_

Illnesses \_\_\_\_\_

Age of death \_\_\_\_\_

Cause of death \_\_\_\_\_

Siblings: No. Brothers \_\_\_\_\_ Age range \_\_\_\_\_

Illnesses \_\_\_\_\_

Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

No. Sisters \_\_\_\_\_ Age range \_\_\_\_\_

Illnesses \_\_\_\_\_

Age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

Do you have children? \_\_Yes \_\_No Age(s): \_\_\_\_\_ Any health problems? \_\_\_\_\_

Have any other relatives had any of the following (include grandparents, aunts, uncles, but exclude relatives by marriage)

Diabetes

Colon cancer

Stroke (prior to age 60)

Heart attack (prior to age 60)

Kidney disease

Other cancer \_\_\_\_\_

Prostate cancer

Ovarian cancer

Other \_\_\_\_\_

Breast disease

Thyroid disease

Patient Name: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

**Have you had any of the following symptoms in the past four months?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Weight Loss/gain          | <input type="checkbox"/> Joint swelling or pain              | <input type="checkbox"/> Sleep problems                    |
| <input type="checkbox"/> Fever                     | <input type="checkbox"/> Chest pain/pressure/heaviness       | <input type="checkbox"/> Face pain                         |
| <input type="checkbox"/> Night Sweats              | <input type="checkbox"/> Stomach/abdominal pain              | <input type="checkbox"/> Loss of strength or speech        |
| <input type="checkbox"/> Loss of consciousness     | <input type="checkbox"/> Loss of appetite                    | <input type="checkbox"/> Difficulty concentrating          |
| <input type="checkbox"/> Headache                  | <input type="checkbox"/> Nausea/vomiting                     | <input type="checkbox"/> Anxiety                           |
| <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Diarrhea                            | <input type="checkbox"/> Depression/tearfulness            |
| <input type="checkbox"/> Change in eyesight        | <input type="checkbox"/> Constipation                        | <input type="checkbox"/> Hot flashes                       |
| <input type="checkbox"/> Hoarseness                | <input type="checkbox"/> Black or bloody bowel               | <input type="checkbox"/> Hair loss                         |
| <input type="checkbox"/> Ears ringing/hearing loss | <input type="checkbox"/> Heartburn/indigestion               | <input type="checkbox"/> Extra heart beats or racing heart |
| <input type="checkbox"/> Shortness of breath       | <input type="checkbox"/> Difficulty swallowing/food sticking | <input type="checkbox"/> Unusual bruising or bleeding      |
| <input type="checkbox"/> Swelling of ankles        | <input type="checkbox"/> Yellow eyes/skin                    | <input type="checkbox"/> Nose bleeds                       |
| <input type="checkbox"/> Nasal congestion/drainage | <input type="checkbox"/> Frequent urination                  | <input type="checkbox"/> Sexual difficulties               |
| <input type="checkbox"/> Cough                     | <input type="checkbox"/> Difficulty urinating/incontinent    | <input type="checkbox"/> Leg cramps                        |
| <input type="checkbox"/> Coughing up blood         | <input type="checkbox"/> Blood in urine                      | <input type="checkbox"/> Changes in wart/mole/skin growth  |
| <input type="checkbox"/> Wheezing                  | <input type="checkbox"/> Excessive tiredness                 | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> Backache                  |  |  |

Date and location of your most recent hospital admission: \_\_\_\_\_

Date and location of your most recent ER visit: \_\_\_\_\_

Date and location of your most recent doctor office visit: \_\_\_\_\_

Special ambulatory needs or limitations: cane, walker, wheelchair, other: \_\_\_\_\_

Physical disabilities-please list: \_\_\_\_\_

Hearing impairment? \_\_Yes \_\_No If yes, please describe: \_\_\_\_\_

Vision impairment? \_\_Yes \_\_ No If yes, please describe: \_\_\_\_\_

Last complete eye exam (date and provider): \_\_\_\_\_

Do you have trouble chewing or swallowing? \_\_Yes \_\_No Explain: \_\_\_\_\_

Dentures (including partials)? \_\_Yes \_\_No

How many meals a day do you eat on average? \_\_\_\_\_

Do you need assistance with meals? \_\_Yes \_\_No If yes, please describe: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Sex assigned at birth?  Male  Female  Intersex

Legal Sex (based on Govt. ID)  Male  Female  Non binary

Gender Identity? (Check all that apply)  Male  Female  Non binary  Transgender  
 Other: \_\_\_\_\_

Sexual orientation? \_\_\_\_\_

Have you ever had an abnormal pap smear?  If yes, when? \_\_\_\_\_ Date of last period \_\_\_\_\_

Date of last pap smear? \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have irregular menstrual bleeding?  Do you have painful periods?

Do you have vaginal discharge?  Have you bled after menopause?

Number of pregnancies \_\_\_\_ Number of live births \_\_\_\_ Number of living children \_\_\_\_

Hysterectomy?  If yes, When? \_\_\_\_\_ Why? \_\_\_\_\_

Are ovaries still present?  Do you perform monthly self-breast exams?

Date of last mammogram? \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have breast lumps/nipple discharge? \_\_\_\_\_

**Sexual History**

Do you have known risks for HIV or other Sexually Transmitted Infection? \_\_\_\_\_

Are you sexually active?:  Yes  No If so, with: (circle all that apply) Men Women Both

Have you had multiple sexual partners in the last 6 months?  Yes  No

Have you been treated for a Sexually Transmitted Infection in the past year:  Yes  No

Do you use condoms?  Yes  No Do you use a Birth Control Method? \_\_\_\_\_

\*\*\*\*\*

\_\_\_\_\_  
Signature of patient or Relationship Date  
responsible party

Name of caregiver and phone number: \_\_\_\_\_

\_\_\_\_\_  
Reviewed by Date

*Faculty Internal Medicine, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex*



## **Cancellation, Rescheduling and No Show Policy**

We understand situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel or reschedule your appointment that you provide 24 hour notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot.

Office appointments which are cancelled or rescheduled with less than 24 hour notification may be subject to a **\$25.00** fee. Any test/procedures cancelled or rescheduled with less than 24 hour notification may be subject to a **\$50.00** fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or test/procedure appointment will be considered as NO SHOW. Patients who no call/no show two or more times in a 12 month period may be dismissed from the practice. Patients may also be subject to a **\$25.00** fee for an office appointment no call/no show or a **\$50.00** fee for a test/procedure no call/no show. Patients who show up *after* their scheduled appointment time are considered no call/no show and may not be seen.

The above fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel or reschedule within 24 hours. Fees in this instance may be waived with management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation, Rescheduling and No Show Policy.

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

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date

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