



**PIEDMONT INTERNAL MEDICINE, PULMONARY  
AND INFECTIOUS DISEASES, P.A.**

**CANCELLATION AND APPOINTMENT RESCHEDULE POLICY**

Please be advised that each patient is **responsible** for keeping scheduled appointments that are made by the patient (or a representative of the patient) in the office or by telephone. If appointments are made in the office, each patient will receive a remind appointment card at that time.

It is the **responsibility** of the patient to keep his/her appointment with or without a reminder call from the office. Any appointment not **KEPT** or **CANCELLED** within a **24-hour** notice of the scheduled appointment time will result in a charge of **\$50.00**. In addition, if any patient misses **3 consecutive visits**, without notice, this will result in immediate dismissal from this practice.

**I HAVE READ AND UNDERSTOOD THE TERMS OF THIS POLICY AND AGREE TO COMPLY WITH ITS STATUES.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medical Release**

I hearby give permission to the staff of Piedmont Internal Medicine, Pulmonary and Infectious Disease and PA to release my medical records/history to any insurance companies, physician or hospital involved with my care, or any agency that is instrumental with public and financial assistance.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_