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Patient Acknowledgement: Cancellation Policy

A cancellation, reschedule, or no-show to an appointment or procedure significantly limits our ability to make the appointment available for other patients and consumes valuable office resources. To aid in of efforts of providing care to all our patients, Colorectal Health Northwest has the following Appointment Cancellation Policy.

No show/Cancellation/Rescheduling Fees for Procedures

If a procedure needs to be cancelled or rescheduled, you must notify us at least 7 business days ahead of your procedure time.

You may be charged a $150 administration fee for insufficient notice for a procedure cancellation or reschedule. This fee is not applied to the cost of the procedure and must be paid prior to being rescheduled.

No show, canceled or rescheduled procedures done more than 7 business days in advance will not be assessed a fee.

If a procedure is rescheduled more than once (even with 7 days' notice), may be charged a $150 administration fee. This fee is not applied to the cost of the procedure and must be paid prior to being rescheduled.

No show/Cancellation/Rescheduling Fees for Office Visits

If an office visit needs to be cancelled or rescheduled, you must notify us at least 3 business days ahead of your appointment time.

You may be charged a $75 administration fee for insufficient notice for an office visit cancellation or reschedule. This fee is not applied to the cost of the appointment and must be paid prior to being rescheduled.

Office visits canceled at least 3 business days before scheduled visit will not be assessed this fee.

If an appointment is rescheduled more than once (even with 3 days' notice), you may be charged a $75 administration fee. This fee is not applied to the cost of the appointment and must be paid prior to being rescheduled.

If you have any question regarding this policy, please let our staff know, and we will be glad to clarify.

Please sign and date below, signifying your understanding and agreement to this policy.

I have read and understand the Cancellation Policy and I acknowledge its terms. I also understand and agree that such terms may be amended from time-to-time by the clinic.

Patient Name Patient Signature Date