Surya N Challa MD PC
300 Medical Parkway Suite 208
Chesapeake, VA 23320
P: 757-819-7633 F: 757-819-7665

Chesapeake
Vein Center and MedSpa

Cancellation Policy/No Show Policy
For Office Appointments and Surgery

1. **Cancellation/No Show Policy for Office Appointment**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, if you do not call us to cancel your appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
If an appointment is not cancelled at least 24 hours in advance or you are a no show, you will be charged a fifty-dollar ($50) cancellation fee; this will not be covered by your insurance company.

2. **Cancellation/No Show Policy for Hospital Surgery**

We understand that there are times when you must miss a surgery due to emergencies or obligations for work or family. When we schedule your hospital surgery, multiple parties are involved (hospital, physician, preop testing, radiology etc.). We schedule into a limited number of slots for surgeries. We reserve a block of physician and hospital time for your surgery. Hence, cancellations without adequate notice are severely disruptive and add significant expenses for the office. When you give us adequate notice, we schedule another patient into your slot.
If surgery is not cancelled at least 3 days in advance or you are a no show, you will be charged a two hundred-dollar ($200) fee; this will not be covered by your insurance company. If you have to cancel for a medical reason, we will need proof of medical documentation to avoid charging you a fee.

3. **Office Rescheduling Policy in case of physician emergencies**

We will do our best to communicate any schedule changes to you ASAP. As a surgeon, your physician may occasionally be called on to respond to medical emergencies. We will give you immediate notice if such changes occur and will do our best to reschedule you.

I _____HAVE REVIEWED ABOVE POLICY. I UNDERSTAND AND AGREE WITH THE TERMS SET FORTH.

_____ _____ ___/___/_____
Print Name Patient **Signature Patient/Guardian** **Date**