PULMONARY CARE
OF CENTRAL FLORIDA

I _____ understand that in

the event I fail to keep my scheduled office appointment with Pulmonary Care of Central Florida, without a minimum of 24-hours notice of cancellation, I will be responsible for a $25.00 “No Show” fee which is not reimbursable by insurance.

Should I fail to give the required 48-72 hour cancellation notice for a Sleep Study, I agree that Pulmonary Care of Central FL may bill me for $125.00 which I understand is not reimbursable by my insurance company. (Please note that the No Show or late cancellation fee is $250 if you are scheduled for an MSLT and fail to give 72-hours notice prior to cancellation of the test.)

Please understand that Pulmonary Care of Central FL recognizes that there are emergencies that may on occasion prevent our patients from keeping scheduled appointments. We will make every effort to work with your situation.

_____ _____/____/_____
Patient Signature Date

_____ ____/____/_____
Witness Date