



# Patient Consent

I, \_\_\_\_\_ give my permission to any of the doctors or staff of Virginia Cardiovascular Associates to speak to the following people regarding my medical care:

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

I give the staff at Virginia Cardiovascular Associates permission to leave a message regarding satisfactory test results.

YES  NO \_\_\_\_\_ **Initials**

Please leave a message on my:

Home phone: \_\_\_\_\_  Cell phone: \_\_\_\_\_

Print Name: \_\_\_\_\_

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

## Notice of Cancellation Policies

Effective June 1, 2011, Virginia Cardiovascular Associates, Manassas Heart Center, and Warrenton Heart Center will implement the policies outlined below.

**OFFICE VISIT:** 24 hours notice is required to cancel an office visit appointment.

The following fees will be charged for no-show appointments and cancellations with less than 24 hours notice:

New Patient Visit	<b>\$150.00</b>
Established Visit	<b>\$75.00</b>
Nursing Visit	<b>\$25.00</b>

**PROCEDURES:** 48 hours notice is required to cancel a procedure appointment.

The following fees will be charged for all no-show appointments and cancellations with less than 48 hours notice:

Stress Test	<b>\$150.00</b>
Echocardiogram	<b>\$150.00</b>
Stress Echo	<b>\$150.00</b>
Thallium Stress	<b>\$150.00</b>
Carotid Doppler	<b>\$150.00</b>
Lower Extremity	<b>\$150.00</b>

I agree that I have been notified, in writing, of the policy changes for VCA, MHC and WHC. I understand that if I fail to comply with these policies, I may be subject to the charges outlined above. I also understand that missed appointment charges must be paid before subsequent appointments can be honored.

Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_