

California Sleep Labs

Sleep Study Cancellation/Reschedule Policy

We will make every effort to accommodate your scheduling needs. When your sleep study is scheduled we reserve a room specifically for you at The Four Seasons and coordinate arrangements with a variety of people involved in with the sleep studies, including Sleep Technologists, Scoring Technologist, and Physicians. We only schedule two patients per a sleep tech to ensure sure you receive the highest level of care and the best study results. Since we have limited space for patients and have to coordinate many arrangements in advance with a diverse array of people on our team we require that you notify us at least 72 hours in advance of your sleep study date if you need to reschedule or cancel.

With less than 72 hours notice we are often unable to accommodate other patients who may be waiting for a sleep study and also inconvenience all the people who have made clinical and administrative arrangements for your sleep study. As a result, we charge a cancellation fee of \$250 if you do not notify us 72 hours in advance.

Please read and sign our policy as indicated below:

ALL PATIENTS WHO CANCEL OR RESCHEDULE WITH LESS THAN 72 HOURS NOTICE WILL BE CHARGED A CANCELLATION FEE OF \$250.00 REGARDLESS OF WHETHER YOUR SLEEP STUDY WAS SCHEDULED LESS THAN 72 HOURS BEFORE YOUR SLEEP STUDY APPOINTMENT.

IF YOU ARE SICK OR HAVE A FAMILY EMERGENCY YOU WILL STILL INCUR A \$250 CHARGE. IF YOU RESCHEDULE YOUR STUDY AND SUCCESSFULLY COMPLETE IT WE WILL REFUND YOUR \$250.

- This surgery cancellation fee is NOT covered by insurance and is your responsibility to pay.
- If you do not give 72 hours notice you will be charged a fee of \$250.00.
- This fee will be charged to your credit card on file in our office.

If you need to cancel or reschedule your sleep study please contact Marieline Fouché between the hours of 8:30am and 4:30pm, Monday through Friday. Marieline can be reached at 650.462.3178.

Thank you for your assistance in complying with our policy.

I have read and understand this policy.

Patient Name (please print) _____

Patient Signature _____
Signature **Date**

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