Gastroenterology of Greater Orlando

Board Certified in Gastroenterology

BIOFEEDBACK CHECKOUT FORM

Provider: _____ **Scheduled by:** _____

Biofeedback Therapy:

Treatment #1: _____ Time: _____ Location: _____
Treatment #2: _____ Time: _____ Location: _____
Treatment #3: _____ Time: _____ Location: _____
Treatment #4: _____ Time: _____ Location: _____
Treatment #5: _____ Time: _____ Location: _____
Treatment #6: _____ Time: _____ Location: _____

Anorectal Manometry Date and Time: _____

	OFFICE	ADDRESS	PHONE #
	ORANGE CITY	2884 Wellness Avenue, Suite 100 | Orange City, FL	386-668-2221
	LAKE MARY	835 Currency Circle, Suite 1001 | Lake Mary, FL	407-749-6656
	DELAND	929 N Spring Garden Ave, Suite 150 | DeLand, FL	386-339-2692

Follow-up date and Time: _____ **Provider:** _____

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CANCELLATION FEES

I understand that missed or cancelled appointments are subject to the following fees:

Surgical Center or Hospital Procedure with less than 72 hours' notice $75
In-office Procedure with less than 24 hours' notice $50
Office visit with less than 24 hours' notice $25

In addition, I understand that missed appointments or appointments cancelled without required notice may result in a fee charged by the applicable Surgical Center, Hospital, or other facility. I understand that there is a charge for returned checks for any reason (check with your office's staff for specific fees charged). Failure to remedy the returned check may result in legal action. Additionally, there may be a fee charged for completing forms (check with your office's staff for specific fee charged) and copying medical records in accordance with state laws.

_____ Name _____ DOB _____ Signature _____ Date

Please call our office if you have any questions or concerns.