PEARLAND CARDIOVASCULAR ASSOCIATES

Patient Name:_____**DOB**:_____

By initialing below, I acknowledge that I have read and understand the office policies and I will follow all of them.

Cancellation/No Show Policy

If you need to **RESCHEDULE** or **CANCEL** an appointment, kindly notify us **24 HOURS** prior to your scheduled appointment by calling during our business hours (Monday-Friday 9am to 5pm). Failure to provide notification will result in a **$25 cancellation charge/fee** that will have to be collected on your next visit.

Initial:_____

Refill Request

Please allow **3 business days to respond back** to your refill request. When you have **1 week of medication** remaining, kindly contact your pharmacy to send us and electronic request, so we can E-Scribe (electronically send the prescriptions back to pharmacy) in a timely manner. Refills will not be approved if you have missed your appointment or it is time for your follow up.

Initial:_____

Forms Fill Out Fee

For **ANY** forms such as short-term disability, life insurance, leave of absence… etc. that needs to be filled out by Dr. Bhuriya, there will be a **$25 processing fee**. Please allow 7-10 business days for the paperwork to be completed.

Initial:_____