GWINNETT CLINIC

GWINNETT CLINIC CANCELLATION POLICY

NUCLEAR (THALLIUM) STRESS TEST
GWINNETT CLINIC CARDIOLOGY
TEST LOCATION :
475 PHILIP BLVD, SUITE 200
LAWRENCEVILLE, GA 30046
P: (678)226-6200   FAX: (678)240-2152

NAME: _____   **DOB:** _____

ACCOUNT: _____   **EXAM:** _____

1. This test is done in the Lawrenceville office on the 2nd floor.

2. We require a minimum notice of 4:00 PM EST the day prior to your test to cancel or reschedule without penalty.

   – **If you need to cancel** or reschedule this test, please call 678-226-6200 Monday-Friday during the hours of 9:00 AM - 1:00 PM and 2:00 - 6:00 PM and speak to Patsy or Jennifer. You must speak directly with one of these two people. Do not leave a voicemail.

3. The radioisotope used for this procedure is ordered specifically for your test. It is good for six hours and must be discarded if not used within this timeframe. **Failure to cancel, reschedule, or not show up for your appointment will result in a charge to you (not to your insurance company) of $400 to cover cost of the radioisotope.**

4. This test requires advance preparation on your part. Instructions are attached or can be found online www.gwinnettclinic.com/HeartTest for your preparation. Failure to follow these instructions can result in cancellation of your test. You will be responsible for the charge should this happen. Please be sure to arrive on time. If you are more than 10 minutes late, this could result in the cancellation of your appointment and we may move on to the next scheduled patient.

5. If you suspect you are pregnant, please notify your doctor before the day of your test. You must have a cardiology consultation before the test, which is a separate office visit charge and will be collected at the time of your stress test.

6. Due to limited space, family members may be asked to remain in the waiting room.

I have decided *not* to have this test. My provider has explained to me the possible risks of NOT having this examination.

_____   _____
Patient/Representative Signature   **Patient/Representative Print Name**

_____   _____
Witness Signature   **Witness Print Name**