FINANCIAL POLICY FOR PATIENT ACCOUNTS

PLEASE READ AND SIGN—BRING TO YOUR APPOINTMENT

Dear Patient,

Thank you for choosing our Practice/Endoscopy Center as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that the payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, and we require that you **read and sign** this policy prior to receiving any treatment. If you choose not to sign this Financial Policy, we have the right to cancel your appointment.

PURPOSE, SCOPE AND GENERAL:
Purpose: The purpose of this policy is to provide guidelines regarding payment to our Practice for medical services rendered to patients.

Scope: This policy applies to patients and patient accounts.

General: We are committed to providing you with the finest medical care at a most reasonable cost. Prompt payment of fees for services rendered enables us to keep our fees at the lowest level possible. In order to meet this commitment, we need your assistance and your understanding of our payment policy.

Patients with Medical Insurance:
Our Practice accepts most major insurance companies. It is critical that you, the patient, check with your insurance company as well to make sure we are in network with **YOUR** plan.

Patients without Medical Insurance:
Patients with no insurance or part of a cost sharing/discount plan (not insurance) will be required to pay for the **procedure** in its entirety before or the day of the procedure.

We will check if pre-certification is required for any testing and procedures, but it is the patient's responsibility to check your plan for benefits.

We MUST HAVE A COPY OF YOUR INSURANCE CARD(S) so that we may bill both the primary and the secondary insurance company if applicable. **Every year a new Signature on File Form is REQUIRED** and all information must be completed including your insurance information on the form (even though we scan your card).

Your insurance policy is a contract between you and your insurance company. Please be aware that very few insurance companies attempt to cover all medical costs and it is your responsibility to verify your coverage policies and benefits.

PATIENT ACCOUNT INFORMATION:

- **Statement balances** are due within thirty (30) days, late fees may apply after that time.
- **Payment Plans** can be set up with the Billing Department.
- **No-Show patients** will be charged $25 for a missed appointment and $100 for a missed procedure. **24-hour notice is required for OFFICE cancellations and 48 hours for PROCEDURE cancellations**.
- **Copayments** are required prior to seeing the provider. We accept cash, checks, MasterCard, Visa and Discover.
- **Returned checks** for non-sufficient funds or stop payment will be billed a $35 charge.
- **Failure to pay your account balance in a timely manner may result in you account being forwarded to a collection agency.**

I authorize the release of any medical information necessary to process this claim: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance and other health plans to our Practice/Endoscopy Center.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

X_____ X_____
Patient Signature Date

_____
Patient Name- Please Print