

GastroIntestinal Healthcare Financial Policy

Thank you for choosing us as your health care provider. We are committed to giving you the best care available.

Insurance:

Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. We do accept assignment of your benefits, however, please be aware that some or all of the services provided may be a non-covered service under your plan. You will be responsible for these non-covered charges. It is your responsibility to:

- Ensure that we actively participate with your insurance carrier/plan
- Know your benefit coverage
- Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits.

Please remember that we must receive your billing information at the time of each visit in order to meet claims submission guidelines set by your insurance plan. If either the practice or the plan fails to receive accurate information necessary to process your claim, you will be held responsible.

Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred.

In summary, your financial responsibility pertains to:

- Denied and Non-covered services
- Services deemed not medically necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pending claims due to lack of patient and/or guarantor information
- Non-insurance and/or out of network benefits

Please be aware that if your insurance company has not paid within 60 days, your balance may be transitioned to patient responsibility and you may be required to make other payment arrangements.

Self Pay

Patient must pay in full at time of service.

Missed Appointments

Please provide us with a 24 hour notice of cancellation so that we may utilize our schedule to provide better patient care. If you don't offer at least 24 hours advance notice, we may charge you a \$25.00 missed appointment fee. This charge will not be billed to your insurance company.

Collections

Any past due balances not paid may be turned over to a collection agency after 90 days,

I have read and agree to this financial policy:

X _____ Date: _____

Signature of Patient or Responsible Party