Digestive Care Center

Name: _____

Acct #: _____

Dr: _____

Payment Policy and Agreement

Dear Responsible Party,

We are committed to providing the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

You will be financially responsible for all charges on your account with Digestive Care Center and/or Gastrointestinal Endoscopy Center, including charges not paid by your insurance company or health plan as a result of co-payments, coinsurance and deductibles. Our office will file all claims with the patient's insurance company or health plan and bill the patient for any remaining balance. You will be responsible for **payment in full of any balance on your account (including deductibles, co-pays, coinsurance or non-covered services) upon receipt of your Explanation of Benefits from your insurance company or a balance due statement from our office**. Co-pays and coinsurance are due at the time of the visit.

As a courtesy to our patients, Digestive Care Center will contact your Insurance Company to obtain Authorization or Pre-certification of procedures scheduled by our office, but it is **the patient's responsibility to contact their insurance company to determine what services are covered and what the insurance company's payment benefits are.** The patient is responsible for any and all charges and fees not covered by insurance. Please carefully review your policy in advance or contact your insurance company since your insurance coverage is a contract between you and your insurance carrier.

Patients with **High Deductibles and/or Health Savings Accounts** will be required to pay their deductible prior to procedures being performed. Payment for office visits will be due at the time of the visit.

Patients who are **self-pay or uninsured** will be required to pay in full the estimated charges prior to procedures being performed. Payment for office visits will be due at the time of the visit.

We accept payment by cash, check, Visa, MasterCard or Discover. Patients may be able to qualify for **monthly, interest free financing options** as an alternative to paying the balance in full by cash, check, or credit card. If an alternative payment arrangement is required, then arrangements must be made in advance with the Digestive Care Center Insurance/Billing Department. There will be a $25.00 service charge on all returned checks.

**Please note, Digestive Care Center does not have the ability to accept monthly payments on account balances outside of the pre-approved financing options. Patients will have 25 days from the receipt of their statement to have balances paid in full. Account balances not paid in full may result in further collection activity and may be forwarded to a collection agency.

PAYMENT AGREEMENT:

I request that payment of authorized insurance benefits (including, but not limited to Medicare, Medicaid, HMO, PPO, BC/BS and Workers Compensation) be made on my behalf to Digestive Care Center or Gastrointestinal Endoscopy Center for any services furnished me by physicians or employees of Digestive Care Center. I authorize any holder of medical or other information about me to release to my insurance company and its agents any information needed to determine these benefits or benefits for related services. I request that any other insurance benefits be paid directly to Digestive Care Center. I authorize the Digestive Care Center to submit claims to my insurance carriers or their intermediaries for all services rendered by the Digestive Care Center. I authorize the release of any information required to process any claims.

I understand that I am financially responsible for any balance regardless of insurance coverage, if any, subject to Federal Law concerning payment for services provided to a patient of the Digestive Care Center. I also agree to be responsible for reasonable attorney's fees, court costs and other collection expenses (including but not limited to returned check fees and cancellation fees) incurred by the Digestive Care Center whether service was extended at our facility or another facility.

_____ _____

Patient Name (Print) Patient Signature/Patient Authorized Representative

_____

Date

GA204

Digestive Care Center Copy – White Patient Copy - Yellow