

Digestive Health Specialists, P.A.

FINANCIAL INFORMATION

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's health care and the financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, or your insurance coverage and your responsibilities.

Professional Fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's education, training, and support costs associated with providing and coordinating your care. We will be happy to provide you with detailed fee information at any time.

Patient Payments: Co-pays, deductibles, services not covered by your insurance plan or outstanding balances are due at the time of your appointment. We will mail you (1) one statement reflecting any balance due. A \$5.00 billing fee will be charged to your account for each additional statement we send you with unpaid balances over 35 days old. Payments may be made with cash, check, or credit card. Returned checks will be subject to a **\$20.00 fee**. Feel free to discuss with our Billing Department Staff, a mutually acceptable payment plan if you are having a particular financial problem.

Insurance Payments: We participate and accept assignment of payment with most major insurance plans in the area. If you provide us with your correct insurance policy information and any needed referral forms, we will file, as a courtesy to you, up to two separate insurance claim forms free of charge for each service you receive. A \$15.00 fee will be charged for each additional claim form you ask us to submit on your behalf. Even though we may submit insurance claims for you, your insurance coverage is a **contract between you and your insurer** and you are still responsible for payment of services regardless of the amount your insurance pays.

Additional Fees:

Missed Appointments: Please understand that when you reserve an appointment with one of our physicians we are making a commitment to your medical care and this prevents another patient from receiving care at that time. In order to provide all of our patients with appropriate access to our physicians we may charge a \$25.00 fee for any office appointment that is canceled with less than 24 hours notice and a \$75.00 fee for any procedure appointment canceled with less than 72 hours notice.

Medical Forms: The completion of disability forms, attending physician statements, and other supplemental insurance forms all require physician and staff time to complete, accordingly a \$20.00 fee will be charged to complete most of these forms. Non-standard forms may be higher.

Collection Agencies: If it becomes necessary to place this account with a third party for collection agency, the person responsible for the account will be charged a collection agency fee on the unpaid balance. Your signature on this page constitutes an agreement to this policy.

Nurse Visit: Please note that if a patient comes in without an appointment to speak to a nurse, there will be a charge for that visit.

I guarantee payment to Digestive Health Specialists, P.A. for all charges for services provided to me and understand that I am personally responsible for all charges not covered by my insurance. I authorize payment directly to Digestive Health Specialists, P.A. for any surgical or medical benefits, if any, and otherwise payable to me for all services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct. I authorize the transfer of monies paid to DHS and otherwise refundable to the Patient or Guarantor, to other accounts at DHS for any other account which Patient or Guarantor is responsible.

I have read and agree to the above policies and have had the opportunity to ask questions and my questions have been answered.

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT _____

DATED _____