

BAYFRONT DIGESTIVE DISEASE FINANCIAL POLICY

We are committed to providing you with the best possible care available at a cost that is both fair and reasonable. The following is a summary of our financial policy. Bayfront Digestive Disease Associates, P.C. is dedicated in helping you receive your maximum benefits available. In order to achieve this goal, we need your assistance and your understanding of our payment policy. We would be happy to provide you further clarification if necessary. We must emphasize that as medical providers our relationship is with you, not your insurance company. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided by us.

IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH COMPLETE INSURANCE INFORMATION INCLUDING SUBSCRIBERS NAME, DATE OF BIRTH, ADDRESS, SS# AND EMPLOYER AND TO INFORM US OF ANY CHANGES THROUGHOUT THE YEAR. WE CANNOT FILE CLAIMS WITHOUT THIS INFORMATION.

- We accept cash, checks, money orders, Visa, MasterCard and Discover.
- **Co-payments for office services are required at the time of your visit. If you fail to bring your co-pay, we may have to reschedule your office visit with us.**
- Our office submits insurance forms as a courtesy and service to our patients. We are not obligated to perform this service except for plans which we have a participating agreement.
- All charges are your responsibility from the date services are rendered and are to be paid in full within 90 days.
- Returned checks are subject to a handling fee of \$25.00.
- The cost of medical care is determined by the nature and complexity of the illness. There is no "flat rate" for examinations and treatment.
- Always return your statement stub with your payment and include your account number if you pay by check. If you do not have the stub, be sure the patient's full name and account number are on your check.
- Regardless of the type of insurance coverage you have, you are ultimately responsible for paying your medical bills. The fees charged at Bayfront Digestive Disease compare favorably with other gastroenterologists in this region.
- Unresolved balances may be placed with an outside collection agency. These unresolved balances may also be subject to finance charges, attorney fees and collection agency fees. **Once an account has been placed for collection, future appointments will be at the discretion of the physician and the full collection balance needs to be paid before any further service is provided.**

YOU MUST REALIZE THAT:

1. Your insurance is a contract between you and your employer and/or insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

ATTN: WE MAY NOT PARTICIPATE WITH YOUR INSURANCE CARRIER. IT IS YOUR RESPONSIBILITY TO CHECK WITH THEM BEFORE YOUR VISIT.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

3. NO SHOW office visit appointments and appointments that are not canceled at least 24 hours in advanced will be charged an office visit fee of \$50.00. NO SHOW procedures and procedures that are not canceled at least 24 hours in advance will be charged a \$150.00 fee. This fee is charged to me and not my insurance. I agree to pay this fee.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise or if you have any questions regarding the above information, we encourage you to contact our Business Manager who will be happy to discuss any financial issues with you.

**OUR PHYSICIANS DO NOT HANDLE ANY FINANCIAL ISSUES.
PLEASE DISCUSS THESE ISSUES WITH OUR BUSINESS MANAGER.**

I understand that I have financial responsibility for payment of medical services provided by Bayfront Digestive Disease Associates, and hereby assume and guarantee payment of all expenses incurred during my office visit and any further treatment. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Signature of Patient/Responsible Party

Date

Patient's Name

Patient's Date of Birth