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 (2) two statements 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 **$25.00 fee.** Feel free to discuss with our Billing Department Staff, a mutually acceptable payment plan if you are having a particular financial problem.

Past Due Accounts: All **charges not covered by my insurance, more than 70 days past due**, will be charged a past due balance fee in the amount of 25% of the unpaid balance (Minimum Charge of $25.00).

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. 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.

Cancellation / Rescheduled appointments / No-Show Fees

We understand that situations arise in which you must cancel/reschedule your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hour notice. This will enable for another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hour notice, we are unable to offer that slot to other patients. Office appointments which are cancelled with less than 24 hours' notice will be subject to a **$50.00** cancellation fee. Procedure cancellations require 72 hour notice, without notification they will be subject to a **$75.00** cancellation fee. Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as **NO SHOW**. Patients will be subject to **a $50.00 fee for office appointment No Show and $75.00 procedure No Show fee.** The Cancellation and No Show fees are the sole responsibility of the patient and **must be paid in full within 70 days** and will be subject to our **"Past Due Account"** policy above**.** We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Questions about cancellation and no show fees should be directed to the Billing Department (336) 765-4090 Monday – Friday from 9:00 am until 4:00 pm.

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. Payment for these forms must be paid upon completion. Non-standard forms may be higher.

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.

Print Name: _____ Signature of Person Responsible for Account: _____

Date: _____

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