Advanced Gastroenterology PLLC
Advanced Endoscopy Center PLLC

Insured Patient Payment Policy

Patient Responsibility:

- You are responsible for all charges resulting from treatment provided by Advanced Gastroenterology. We bill most insurance carriers. However, primary responsibility for the account is yours. Your co-payment is always due at the time of service; any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. If you have a delinquent balance, we may ask you to make a payment at the time of your next visit with us.
- Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

Insurance Billings:

- It is your responsibility (or that of the financially responsible party) to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.
- Medicare: We participate with Medicare. We will bill Medicare as your primary insurer. We will also bill your supplemental insurance provider.
- Medicaid: Please bring your current medical card with you to each appointment.

Check Returned:

It is our office policy to charge a $35 fee for checks that are returned due to non-sufficient funds.

Authorization to Release Information:

- In obtaining payment for services, I authorize my healthcare provider, Advanced Gastroenterology to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including but not limited to: my insurance companies and their representatives, and my employer or union if they are involved in processing the claim. *For further information regarding disclosure of health information, please refer to the Notice of Privacy Information Practices available in our office.*
- If I have been referred by, or am referred to another healthcare provider, I authorize Advanced Gastroenterology to release my medical information to this provider for continuing care.
- I also assign Advanced Gastroenterology all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by my insurance provider or not. I also understand that balances outstanding for more than 90 days may be subject to a processing fee.

I, or my appointed agent, have read, fully understand, and agree to the above statements. I can request a copy of this policy at any time.

Patient's Name (please PRINT)	Patient's Signature	Date

If the patient is under the age of 18 years, or is otherwise unable to sign, complete the following:
Patient is _____ year(s) of age or is unable to sign because: _____

Patient's Name (please PRINT)	Guarantor's Signature	Date

Date

Sign below if disclosure of information is NOT authorized:
Therefore, I agree to pay for costs of all treatment and services personally.

Patient's Name (please PRINT)	Patient's Signature	Date

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