GI SURGICAL SPECIALISTS, LLC

FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

PAYMENT POLICY: Payment co-payments and deductibles are due and payable in full at the time services are provided.

PATIENTS WITH INSURANCE: We bill most insurance primary and secondary carriers for you if paperwork is provided to us. Your agreement with your insurance carrier is private; we do not regularly investigate why a carrier has not paid or why payment was less than anticipated. If an insurance carrier has not paid within 60 days from the submission, you are responsible for full payment.

MEDICARE PATIENTS: We will bill Medicare and secondary insurance carriers for you.

SURGERY FEES: All co-pays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Your carrier may require prior authorization. For proper staffing of the OR, Anesthesia and Physicians we require at least 3 business days' notice to cancel your surgery. **If proper notice is not given, you will be charged a $100 cancellation fee.**

NON-COVERED SERVICES: Any care not paid for by your existing insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES: This office does not bill for automobile accidents, other liability or lawsuit-related cases, therefore you are responsible for payment at the time of service.

WORKER'S COMPENSATION: In order to bill the worker's compensation insurance company, we will need the case number and carrier name, billing information, and authorization in writing prior to your visits.

YEARLY HEALTH CHECKS: Preventative care checks may or may not be covered under your health insurance policy, even though your physician may require them. You will be responsible for any preventative care not covered by your insurance. Please inform us if you have preventative care coverage.

MISSED APPOINTMENTS: In all fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments or you may be charged for missed appointments.

I have read, understood, and agreed to the above financial policy for payment of professional fees.

Signature: _____ Date: _____