Gastroenterology Specialists, Inc. & ASC Financial Policy

Effective 7.30.2015- Updated 11/2/2023

Our goal is to provide excellent medical care in a comfortable, personal, and cost-effective manner. Our financial policies have been developed to help lower the cost of medical care for our patients. You can help by paying for your care in a timely manner.

This policy can be acquired at any time on our website or by calling our office.

Patient Payment Responsibility

Payments to Gastroenterology Specialists, Inc. may be made by cash, check, Visa, MasterCard, Discover, or American Express. Patients are required to provide GSI with correct insurance information and are responsible for all charges incurred as a result of incorrect and/or insufficient information provided.

Please remember insurance is considered a method of reimbursing the patient for fees paid to the physician and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. Patients are expected to pay any copays and/or deductibles at the time of each visit. Patients with no insurance are expected to pay in full at the time of each visit. GSI strives to include all charges at the time of service, but occasionally, charges may be added or modified after the visit. (For example: an additional blood or urine tests may be ordered or the level of service provided during a consultation may be modified per American Medical Association guidelines). GSI will bill all insurance claims as a courtesy to patients, but the patient, **NOT** the insurance provider, is responsible for the payment of all services. Patients who disagree with any charges must contact this office in writing within thirty (30) days of the billing date. A refund will be issued if GSI receives an insurance payment for a charge already paid by a patient. GSI will gladly resubmit a corrected claim if an error was made on the original claim.

Gastroenterology Specialists, Inc. reserves the right to charge a fee for delinquent accounts and for submitting insurance forms after sixty (60) days. If ongoing medical care is needed, patients are expected to make payments on old balances as well as payment in full for new charges at the time of service. Negative or positive account balances of $15 or less will not be collected or refunded. A $35 fee will be charged for returned checks. A $50 service charge may be added to accounts when an unpaid balance remains after two statements have been sent. Accounts with balances over ninety (90) days may be transferred to a collection agency.

Missed, Rescheduled, and Cancelled Appointments

Gastroenterology Specialists, Inc. reserves the right to charge a fee for missed, cancelled, and rescheduled appointments with less than sufficient notice. Our policy requires: (1) sufficient notice (as outlined below) if unable to keep an appointment; (2) applying a fee for missed, cancelled, or rescheduled appointments with less than sufficient notice; and (3) discharging a patient when two appointments are missed or three appointments are cancelled or rescheduled without sufficient notice. New patients failing to keep their first appointment without a sufficient notice may not be granted another opportunity for an appointment. Charges for missed, rescheduled, or cancelled appointments will be billed to the patient directly and will not be filed through insurance.

Cancelled or rescheduled office appointments with less than 24 hours' (2 business days) notice-

1st time: Warning – no charge 2nd time: $50.00 charge 3rd time: Potential discharge from clinic

Missed office appointments- 1st time: Warning and/or $50.00 charge 2nd time: Potential discharge from clinic

Cancelled or rescheduled procedures with less than 72 hours' (3 business days) notice- $100 charge

Missed procedures- $200 charge

Acknowledgement of Financial responsibility & Authorization to Release Information

I understand I am financially responsible for all changes whether or not paid by insurance. I hereby authorize **Gastroenterology Specialists** to release medical information acquired in the course of examination and treatment for the purpose of filing for insurance benefits and other financial coverage. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient record, which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS), until otherwise revoked in writing by the patient or guardian. This authorization to release information shall remain in place until all claims have been paid.

Patient Name/Signature: _____ Date Signed: _____