Patient account # / Name

GASTROENTEROLOGY ASSOCIATES
OCALA ENDOSCOPY A.S.C.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with the highest standard of treatment. A part of this process involves the financial aspect of your treatment; the following information outlines your responsibility in this area.

1. We participate with a number of insurance companies and health plans. You should check with our office to see if your insurance is one that we file. If we do file your insurance, you are still responsible for any deductible or co-pay amount. If we do not file, you will be asked to pay in full and we will provide you with the receipts you will need to obtain reimbursement from your insurance.

2. For any insurance claims filed directly by this office, we will allow 45 days for payment by your insurance company. After 45 days, the balance becomes your responsibility. It is also the patient's responsibility to discover why the insurance has not paid. Please remember that insurance is a contract between you and the insurance carrier—we are not a party to that contract. If we are not participating providers, the filing of insurance claims is a courtesy provided by our office. We will verify insurance for all scheduled procedures; however, verification of benefits is not a guarantee of payment. In addition, the filing of a claim does not imply that we will accept the allowance paid by the insurance company. You are responsible for any amount not paid by your insurance.

3. We do not wish to have anyone denied medical care because of the inability to pay. If you are unable to pay at the time of your service, we ask that you contact our office before the day of your visit to set up a mutually agreeable payment arrangement.

4. If a check is not honored by your bank you may be assessed a charge to cover the additional handling and bookkeeping fees. This charge will be in accordance with Florida law.

5. If you allow your account to become delinquent, we may find it necessary to take appropriate collection action. Any attorney fees, court costs, collection fees and interest charges at 18% will be your responsibility.

Patient Signature

Date