

GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C.
GAINESVILLE ENDOSCOPY CENTER, LLC

FINANCIAL POLICY

- **We participate in most insurance plans, including Medicare.**
 1. It is your responsibility to check with your plan prior to your visit to make sure we are participating physicians. Failure to do this could result in reduced payments by your insurance company.
 - 2. We do not file automobile, general liability, homeowner's or workman's compensation insurance.**
 3. If you have HMO/POS insurance, it is **your responsibility to obtain a referral number** from your PCP prior to being seen. If you fail to obtain this, the bill is your responsibility.

- **You and your insurance company are responsible for your bill.**
 1. We realize that insurance requirements are confusing, but knowing your insurance benefits is your responsibility.
 2. Any questions concerning your coverage should be directed to your insurance company.
 3. We will file secondary insurance but if the secondary insurance denies payment, you are responsible for the balance.

- **If your primary insurance company requires a co-payment, you must make the co-payment at the time of service.**
 1. Failure to pay your co-pay at the time of service will result in a **billing fee of \$25.00**. *Please remember that we are contractually obligated by your insurance company to collect your co-pays at time of service.*
 2. The balance of your charges will be billed to your insurance company. After payment of insurance company, any remaining balance will become patient responsibility which is due upon receipt of statement.
 3. If payment of any service results in a credit balance on either entity, the credit balance will first be applied to any outstanding balance you have before being refunded to you.

- **Proof of current, valid insurance must be provided at time of service.**
 1. If you do not provide this information, you will be considered a self-pay patient.
 2. Self-pay patients are required to pay their office visit charges in full. *Please ask about your advance payment responsibility when making your appointment.*
 3. Failure to pay your office visit charges at the time of service will result in a billing fee of \$25.00.
 4. You will be billed for the balance of your charges. Payment in full will be expected with receipt of your statement.

- **Failure to receive your statement does not relieve you of your financial obligation. It is your responsibility to notify us of any changes in you billing information.**

- **We accept cash, checks, money orders, and major credit cards.**
 1. Returned checks are subject to a \$25.00 return check fee.

- **Past due accounts are subject to our collections process and any fees assessed by a collection agency.**

Patient Signature (or responsible party)

Date