

**DIGESTIVE DISEASE CONSULTANTS
A DIVISION OF ARIZONA DIGESTIVE HEALTH, P.C.
FINANCIAL POLICY**

Thank you for choosing us as your healthcare provider. It is our goal to provide the highest quality medical care and reduce the potential for confusion or misunderstanding in the course of your patient experience. We have adopted the following Financial Policy to be read and signed by our patients prior to commencement of treatment.

INSURANCE: As a courtesy to our patients, we will file your medical claims with insurance plans with which we have an agreement as long as valid insurance information is provided to us. It is the responsibility of the patient to make accurate and detailed insurance information available to us to enable processing of your insurance claim. The patient is to be considered self pay until this information is provided to us. The patient is to notify our office with any insurance changes prior to scheduled appointments. Your insurance policy is an agreement between you and your insurance company. All account balances are the responsibility of the patient and it is not the responsibility of this office to dispute decisions made by your insurance carrier. Payment is due from the patient upon receipt of the first statement from our office. **If payment is not received within 60-days of receipt of the initial statement, a \$10.00 monthly surcharge will be applied to the account until payment is received.** I understand that if my account is turned over to a collection agency for non-payment I will be responsible for any fees incurred. The patient is expected to know their insurance benefits to include deductibles and co-payments. Co-payments and deductibles are to be paid at the time of service. **If the patient is unable to pay co-payments at the time of the appointment, an additional \$10.00 surcharge will be applied to patient responsibility.** If we are not participating providers with your insurance carrier, or if you do not have medical insurance, all charges incurred during your treatment are due and payable at the time of service.

ALL CHECKS RETURNED FOR NSF (NON SUFFICIENT FUNDS) WILL BE ASSESSED A \$50.00 CHARGE.

REFERRALS/AUTHORIZATIONS: If a referral or authorization is required by your insurance carrier to obtain services provided by a specialty provider, it is the responsibility of the patient to notify their primary care physician to request referrals and authorizations to be provided to our office prior to your scheduled visit.

APPOINTMENTS: If you are unable to keep your scheduled appointment, it is your responsibility to notify our office at least 24-hours prior to your scheduled appointment time so that we can make that appointment time available to another patient. **Failure to do so will result in a \$25.00 charge to the patient.** The patient will be responsible for this fee and it will not be billed to your insurance company.

ADDITIONAL SERVICES: There is a \$25.00 fee charged to the patient which will be collected prior to completion of forms and paperwork when our physicians are requested to complete paperwork for you (i.e. Disability, FMLA forms).

RELEASE OF INFORMATION: I hereby authorize Digestive Disease Consultants, a Division of Arizona Digestive Health, to release information to my insurance company with regard to all treatment as is necessary to obtain payment for their services and to review activity related to the provider's participation with my insurance plan. I assign all benefits to which the patient or insured is entitled for my treatment and medical services provided to me to be paid directly to Arizona Digestive Health, P.C. I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance. I acknowledge that I am bound to pay for services rendered, including all costs of collection and reasonable legal fees should collection become necessary. **I have read and understand this Financial Policy, and by signing am in agreement and accept all terms and conditions described above.**

Signature of Patient or Responsible Party

Date