

MID-FLORIDA GASTROENTEROLOGY GROUP, P.A.

Financial Policy

Welcome to our medical practice. We are committed to providing you with the best possible care and service. Balances owed for services rendered are due at the time services are rendered unless payment arrangements have been approved in advance by our billing office.

-The specialist co-pay(which can be different than my Primary Care co-pay)is to be paid prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that Mid-Florida Gastroenterology also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay. We accept cash, check, VISA, MC, and debit cards. We will file a claim for your primary insurance. A fee of \$25.00 will be charged for any return checks.

-In the event, an account is transferred to an outside collection agency, I understand that I will be responsible for any collection, interest or attorney fee's associated with the collection efforts.

Please realize that: 1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that specific contract.

2. Not all services rendered are a covered benefit with all insurance company contracts that you or your employer may have chosen. It is important for you to have an understanding of the benefits, such as applicable co-pays, coinsurance, deductibles, and regulations associated with your health plan.

-We must emphasize that as a health care provider, our relationship is with you, not your insurance company. Follow up on outstanding claims may require your intervention and we appreciate your working with us in that regard. We realize that temporary financial problems may affect timely payment of your account. However, if such problems should occur, we expect you to contact us promptly for assistance.

-I understand that Mid-Florida Gastroenterology will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective procedures that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective procedure. I further understand that the **FEE I AM QUOTED IS AN ESTIMATE** based on the anticipated procedure to be performed and the current information provided to Mid-Florida Gastroenterology by my insurance carrier.

-I understand Mid-Florida Gastroenterology will obtain the necessary authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

MEDICARE AND MEDICARE SUPPLEMENT INSURANCE

We are a participating provider with the Medicare Part B program; and such are obligated to write off the difference between Medicare's allowed amount and our charge. Medicare pays 80% of that allowed amount to us directly. The 20% co-pay and annual deductible are the patient responsibility by federal law.

POLICIES OF CONTRACTED MANAGED CARE COMPANIES

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is impossible for us to keep track of all the individual requirements of the many various plans. Each one has different stipulations regarding what services may be performed. Even within the same insurance company, the plans differ depending upon what types of contracts you or your employer has requested.

Providing quality medical care for our patients is our primary concern. We will provide that care within your contract guidelines, but we expect you to contact your plan and to actively participate in knowing your plan regulations as services are rendered.

With your cooperation and direction you should be able to receive all the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

My signature below confirms that I have read and understand these financial policies and my financial obligation as pertains to the providers of Mid-Florida Gastroenterology Group, P.A.

Signed

Date