**AMF GASTROENTEROLOGY, INC FINANCIAL POLICY**

Thank you for choosing AMF GASTROENTEROLOGY, INC as your healthcare provider. Our goals are to provide you with excellent gastroenterology care, minimize out of pocket expenses and make paying your balances as easy as possible. Our financial department is dedicated to informing you, to the best of our ability, of your estimated portion of the changes for your care and assisting you with any billing questions you may have.

INSURANCE: For the patient’s convenience, we file medical claims with insurance plans with which we have an agreement, as long as valid insurance information is provided to us to enable processing of his/her insurance claim. The patient is considered to be self-pay until this information is provided to us.

The patient is responsible for notifying our office of any insurance changes prior to scheduled appointments. Insurance policies are an agreement between the patient and his/her insurance company. All account balance are the responsibility of the patient. Payment is due from the patient upon receipt of the first statement from our office.

The patient is expected to know his/her insurance benefits, including deductible and copayments. Copayments and deductibles are to be paid at the time of service. If the patient does not have medical insurance or AMF GASTROENTEROLOGY, INC is not a participating provider with his/her insurance carrier, all the charges incurred during treatment are due and payable at the time of service. If the patients’ deductible or copayments exceed $500.00 we will contact him/her for a deposit prior to the services being rendered.

ALL CHECKS RETURNED FOR NON-SUFFICIENT FUNDS WILL BE ASSESSED AT $35.00 CHARGE

REFERRALS/AUTHORIZATIONS: It is the responsibility of the patient to obtain a referral from his/her primary care physician prior to the scheduled visit if a referral is required to obtain services provided by a specialty provider. If a referral is not obtained, the patient accepts full financial responsibility for all services rendered.

CANCELLATIONS/FEES: If the patient is unable to keep a scheduled appointment or procedure, it is his or her responsibility to notify our office at least 24hrs prior to the scheduled appointment or 48hrs prior to a scheduled procedure. Appointments cancelled after this timeframe may be subjected to a cancellation fee. Additional fees may also be applied to requests for medical records and for physicians completing paperwork for patients (i.e. disability, FMLA forms). These fees are not covered by insurance and the patient accepts full financial responsibility for all additional fees.

RELEASE OF INFORMATION: I hereby authorize AMF GASTROENTEROLOGY, INC to release information to my insurance company with regard to all treatment as is necessary to obtain payment for services and to review activity related to the providers’ participating 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 AMF GASTROENTEROLOGY, INC. I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance. I acknowledge 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.

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Patient/Guardian signature Date