

The following is a statement of our financial policy which you will need to read and sign prior to receiving any services. We also require all patients to give us complete demographic and insurance information prior to or upon arrival at our offices.

FOR PATIENTS WITH INSURANCE COVERAGE, INCLUDING MEDICARE OR MEDICAID

We accept assignment of insurance benefits. We will file a claim with your insurance company for any services you receive. The balance of your account after insurance pays is your responsibility. We cannot bill your insurance company without your insurance information and a copy of your insurance card(s). You are responsible to inform us if you have more than one insurance carrier and which carrier is primary and which is secondary. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 120 days of the date of service, the balance will be automatically transferred to you.

Each insurance plan has different policies about how often services may be provided and where they may be performed. We strongly urge you to be familiar with your policy benefits, especially which outside lab to use, and whether you can have radiology services in our office.

PATIENT RESPONSIBILITY

All co-pays required by your insurance company must be paid at the time of your appointment. This payment is a requirement by your insurance company.

All co-insurance and deductible amounts must be paid within 30 days of your insurance payment or determination of your benefits by your insurance carrier.

If your insurance coverage changes for any reason, it is your responsibility to inform our office and to provide any new insurance information along with a copy of your new card.

FOR PATIENTS WITHOUT INSURANCE COVERAGE

If you do not have insurance coverage, payment for services is expected at the time services are rendered. Our policy is to reduce the rated charged to uninsured patients to approximately the amount that would be allowed by private insurance. We are happy to set up a payment plan with you.

FOR PATIENTS UNDER WORKERS' COMPENSATION

We accept assignment of insurance benefits for patients covered under workers' compensation. We will file a claim with the insurance company for any services you receive. We cannot bill the insurance company unless you give us the information and a contact to call to obtain authorization for services. You are responsible to inform us if your visit is related to a workers' compensation injury.

FOR PATIENTS INVOLVED IN AN AUTOMOBILE OR OTHER ACCIDENT

We accept assignment of insurance benefits for patients involved in an auto accident. We will file a claim with your health insurance company for any services you receive. It is your health insurance company's responsibility to subrogate the claim with your auto insurance or any other party responsible for the accident. [\(over\)](#)

HOW DOES IT WORK?

Following your visit to the office, we will file a claim with your insurance company if you have coverage. After we have received payment from your insurance company, you will receive a statement showing the balance due from you. This amount is your responsibility and is due within 30 days of the statement date. A return-addressed envelope will be included for you to mail in your payment or you may make payments at any of our locations. We accept cash, checks, and major credit cards.

Signature of Patient or Responsible Party

Date

COMMERCIAL INSURANCE / TNCARE

I authorize Gastrointestinal Specialists to release to my health insurance company, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to Gastrointestinal Specialists, P.C.

PATIENT SIGNATURE _____

CHART # _____

MEDICARE

I authorize Gastrointestinal Specialists to release to Medicare and its agents, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to Gastrointestinal Specialists, P.C..

PATIENT SIGNATURE _____

CHART # _____

MEDIGAP (MEDICARE SUPPLEMENTAL POLICIES)

I request payment of authorized Medigap benefits be made on my behalf to Gastrointestinal Specialists, P.C. for ay services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits.

PATIENT SIGNATURE _____

CHART # _____