

LOS PALOS GASTROENTEROLOGY SPECIALISTS INC.

OUR FINANCIAL POLICY

PATIENT (please print): \_\_\_\_\_

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to treatment.

All patients must complete our *information* and *insurance* form before seeing the doctor.

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE FOR NON-INSURED PATIENTS
- WE ACCEPT CASH, CHECK, ALL MAJOR CREDIT CARDS AND CARE CREDIT.
  - o A \$10.00 fee is charged on checks returned from the bank for non-sufficient funds.
- WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL.
- APPLYING FOR CARE CREDIT ONLY TAKES A FEW MINUTES AND THERE IS NO FEE TO APPLY.
- ALL CO-INSURANCE/CO-PAYS ARE DUE AT THE TIME OF SERVICE

**Regarding Insurance**

We cannot bill your insurance unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. The charge is your responsibility whether your insurance company pays or not. Please be aware that some or all of the services provided may be non-covered services. These services may not be considered reasonable and necessary under the Medicare Program or other medical insurance. We will bill any secondary insurance plan for you. All co-pays and deductibles are due prior to treatment.

In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

**Medicare Patients**

All our physicians accept Medicare's assignment. Medicare has a \$166.00 yearly deductible which you may be required to pay if the amount has not been satisfied. At the time of each visit, please be prepared to pay the 20% co-insurance amount.

**Usual and Customary Rates**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Minor Patients**

The adult accompanying a minor and the parents (or guardians) are responsible for full payment.

Thank you for acknowledging our Financial Policy. Please let us know if you have any questions or concerns. Our billing staff can be reached at 831-424-8888, Monday through Friday between 8:00 am and 5:00 p.m.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X \_\_\_\_\_  
Signature of Patient or Responsible Party

Date \_\_\_\_\_

X \_\_\_\_\_  
Signature of Co-Responsible Party

Date \_\_\_\_\_