Dear Patient,

Thank you for choosing Gastroenterology Associates, Inc. (GAI) as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that the payment of your bill is considered a part of your treatment. **The following is a statement of our Financial Policy, and we require that you read and sign this policy prior to any treatment.**

FINANCIAL POLICY FOR PATIENT ACCOUNTS

1. **PURPOSE**
   The purpose of this policy is to provide guidelines regarding payment to GAI for medical services rendered to patients.

2. **SCOPE**
   This policy applies to patients and patient accounts

3. **GENERAL**
   We are committed to providing you with the finest medical care at a most reasonable cost. Prompt payment of fees for services rendered enables us to keep our fees at the lowest level possible. In order to meet this commitment, we need your assistance and your understanding of our payment policy.

   All patients must complete our Patient Information Form and Signature On File Form before seeing the provider.

   Adult patients are responsible for their payments. The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. All minors must be accompanied by a parent or guardian.

4. **PATIENTS WITH MEDICAL INSURANCE**
   GAI accepts insurance from most major insurance companies. While we make every effort to ensure your insurance is accepted at GAI, it is critical that you, as the patient, check with your insurance company as well. We will check to see if pre-certification is required for any testing or procedures but it is the patient's responsibility to check their plan benefits.

   We will file both primary and secondary insurance claims for you at no charge. **WE MUST HAVE A COPY OF YOUR INSURANCE CARD AND A PHOTO ID** in order to bill your insurance company. We cannot bill for you if we do not have a copy of your insurance card. Your co-pay payment is required prior to seeing the provider. Payments can be made by cash, check, MasterCard, Visa, or Discover card.

   Your insurance policy is a contract between you and your insurance company. Please be aware that very few insurance companies attempt to cover all medical costs, and **it is your responsibility to verify your insurance company's benefit coverage policies.**

   We require all patients to assign insurance company payments directly to GAI to avoid any misunderstanding regarding payment for professional services. If you request the insurance company to pay you directly, GAI will require full payment from you at the time of service. Payment for medical treatment is your responsibility whether your insurance company pays or not.

   If you have an outstanding balance that is older than 120 days and you are not making monthly payments, we have the right to refuse to schedule an appointment until the balance is paid in full.

5. **PATIENTS WITHOUT MEDICAL INSURANCE**
   Payment in full is expected for all charges incurred on the day the service is provided. Payment may be made in cash, check, MasterCard, Visa, or Discover card.

6. **ENDOSCOPY CENTER PROCDURE PAYMENTS**
   A charge of $150.00 will be collected the day of your procedure to help cover co-insurance and or deductibles. Straight Medicare and/or Medicaid patients are exempt from this charge. Any additional balances due will be noted on the patient's monthly statement. If for some reason the patient is due a refund following the insurance payment, a credit will be noted on the account if the patient is continuing to see the provider or the credit will be promptly returned to the patient.

7. **PATIENT ACCOUNT PAYMENT**

- **Statement balances** are due within 30 days. We understand that temporary financial problems mat effect your prompt payment. With extensive treatment, payment plan arrangements can be made.
- Financial payment arrangements are required for all patients.
- **Past due accounts** with payment arrangements over 120 days will be subject to a 2% monthly interest charge on the balance due.
- **Delinquent accounts** past 120 days will be referred to a Collection Agency, and may be subject to interest and/or collection fees.
- **Returned checks** for non-sufficient funds will be billed a $35.00 charge.
- **Release of Medical Records** are subject to the current Ohio fee schedule
- **Disability Forms or FMLA Forms** will be completed upon a receipt of a $25.00 Form completion fee. Single page forms will be charged a $10.00 completion fee.

NO SHOW PATIENTS will be charged $25.00 for a missed appointment and $150.00 for a missed procedure appointment. 24 hour notice is required for all cancelations otherwise the appropriate charge will be applied.

Our billing staff is trained to help you with any insurance questions. Remember though, that we can only answer questions relating to how, where, or when your claim was filed. Your employer or group administrator should address COVERAGE ISSUES with you.

Our practice firmly believes that a good physician/patient relationship is based on understanding and good communications. Thank you for understanding the importance of our Financial Policy. If you have any questions about financial arrangements or require assistance in managing your account, contact our billing department at (330) 493-1485.

PATIENT ACKNOWLEDGMENT STATEMENT & SIGNSTURE

II have read, understand and agree to this Financial Policy.

_____ _____

Signature of Patient Date

_____ _____

Signature of Responsible Party if different from Patient Date