



PATIENT FINANCIAL RESPONSIBILITY POLICY

Bucks County Gastroenterology Associates, P.C., (herein referred to as BCGI) firmly believes that a good doctor/patient relationship is based upon open communication and understanding. The following information is provided to avoid any misunderstanding concerning payment for professional services rendered.

I give BCCGI my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations.

1. INSURANCE - As a courtesy to me, (BCGI) will contact my insurance to check for general eligibility and coverage for scheduled appointments. It is my responsibility to check whether a procedure is covered by my insurance or not, or if it will be applied to my deductible or co-insurance. It should be noted that my insurance coverage is an agreement between myself and my insurance company. It is my responsibility to remit payment for charges not covered by my insurance company, and to ensure that my insurance company remits payment for my account. If an insurance claim is denied due to incorrect information that I have provided or if I have not provided the most current insurance information, I will be billed and payment in full will be due immediately. I understand that if I have no insurance coverage, I agree to pay the balance in full at the time services are provided.

2. ASSIGNMENT OF BENEFITS -As a courtesy to me, (BCGI) will file all claims with my insurance company. I authorize direct payment of benefits to (BCGI). If (BCGI) does not have a signed contract with my insurance company, or my insurance company fails to pay my claim in a timely manner, the account balance will be transferred to my responsibility. It is then my responsibility to contact the insurance company about processing my claim. I will be required to make payments on my account during this time

3. PREVENTATIVE CARE - If I am seen for a Preventative Care visit Routine Exam, or Check Up) and discuss or address any non-preventative issues or concerns, I understand that my insurance company will be billed accordingly for the diagnostic treatment. Diagnostic treatment includes, but is not limited to, prescription management, ordering of referrals, labs or imaging for non-screening purposes, review of abnormal lab results or other abnormal test results, and any medical treatment for current symptoms or disease management.

4. NON COVERED SERVICES — It is virtually impossible for us to have knowledge of what services each insurance plan covers. Knowing your insurance benefits is your responsibility. Any questions you may have regarding those benefits or dispute of any services not covered should be directed to your insurance company.

5. STATEMENTS - Each month where there is a balance, I will receive a statement for services which is due and payable each month. If I am experiencing a set of financial circumstances beyond my control, I will call the billing department at (BCGI) Or Billing Representative Ms. Nancy Culver (215-321-7221 x125) so that they can work with me to make payment arrangements.

6. RETURNED CHECK — Any check that is returned to (BCGI) will be assessed a \$25.00 fee. I will be required pay the full amount of the check plus the \$25.00 fee with cash, money order or credit card. I may be placed on a cash or credit card only basis following any returned check.
7. MISSED APPOINTMENTS/CANCEL OR RESCHEDULE WITHIN 24 HOURS (BCGI) cannot provide the quality of care I deserve if I miss a scheduled appointment. This is also an appointment that could have been offered to another patient.
- If I am late for an appointment, I may be rescheduled.
 - If I fail to show for a scheduled appointment, cancel or reschedule within 24 hours of the appointment time, I may be responsible for paying an administrative fee per the following structured fee schedule. Insurance will NOT cover these fees and I will be personally responsible for them.
 - Office Visit: \$50
 - If I No Show, Cancel or Late Reschedule 3 times within one year, I may be blocked from making future appointments
8. NONPAYMENT - Failure to adhere to the above policies may result in my account being turned over to an outside collection agency. Accounts which maintain a past due balance without payment will be assessed a penalty in the form of interest, \$50.00 collection fee and/or attorney fees and court costs. Once an account is turned over to collections, (BCGI) will no longer see or treat me as a patient. Please note once collection activities commence this may be report to credit reporting agencies and adversely impact your personal credit score.

I have read the above financial agreement and agree to abide by the terms set forth in it.

Signature: _____

Date: _____