Bucks County
Gastroenterology
Associates, P.C.

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 to avoid any misunderstanding concerning payment for professional services rendered.

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 note, 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 note 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 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 not limited to, prescription management, ordering of referral, 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 you 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 or billing representative, Megan, 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 to pay the full amount of the check plus the $25.00 fee with cash, money order, or credit card. I may be placed on cash or credit card only basis following any returned check.
7. **MISSED APPOINTMENT/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.
    a. If I am late for an appointment, I may be rescheduled.
    b. 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 and administrative fee per the following structured fee schedule. Insurance will not cover these fees and I will be personally responsible for them
        i. Office Visit - $50.00
    c. If I no show, cancel, or late reschedule 3 times within one year, I may be blocked from making future appointments.
8. **NON-PAYMENT-** 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 and account is turned over to collections, BCGI will no longer see or treat me as a patient. Please note once collections activities commence this may be reported to credit reporting agencies and adversely impact your personal credit score.

I give BCGI 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. I have read the above and agree.

Signature: ____ Date: ______________