FINANCIAL POLICY

MR#_____

Our practice is dedicated to providing the best possible care for you, and we want you to understand our Financial Policy completely.

1. Payment for all co-pays, deductibles, and outstanding patient balances is due at the time of service. We accept cash, checks, and most major credit cards. There will be a minimum charge of $25.00 on all returned checks.

2. Please be advised that your insurance policy is a contract between you and your insurance company.

   We are participating providers with many insurance companies and other health plans, and we will file a claim and accept assignment of benefits on these claims. Payment will be made by the insurance company directly to Florida Digestive Health Specialists, LLP (FDHS).

   If we do not participate with your insurance company, you will be responsible for paying your charges at the time of service. We will, however, provide you with a superbill summary of your visit for you to submit to your insurance company. If your insurance company covers such charges, then the insurance company will pay you directly.

3. Not all insurance companies cover all services. If your insurance company determines a service to be "non covered," you will be responsible for the entire charge. Your payment is due upon receipt of a statement from our office.

4. If you provide incorrect or false information that results in a denial of a claim(s), you will be responsible for any unpaid claims and/or all charges for services provided.

5. We will bill your insurance company for services that were provided to you in a hospital setting. If your insurance company does not pay, you are responsible for any balance due.

6. If the undersigned fails to pay for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred, included but not limited to all reasonable collection fees and/or reasonable contingency fees added by a third party to the outstanding or referred balance.

7. If you cannot keep your appointment for any reason, we require 24 hours notice for office visits. If you do not give us the required notice, your account will be charged a $25.00 no-show fee. If you do not provide 24 hours notice for an ultrasound appointment cancellation, your account will be charged a no-show fee of $50.00. If you do not give 72 hours' notice that you are canceling your procedure(s), you will be charged a $75.00 no-show fee.

8. If the patient or responsible party fails to pay for services rendered under standard practices, then such nonpayment will result in the patient/undersigned's provider, and all providers of FDHS, terminating their provider relationship with the patient/undersigned, in accordance with applicable law. All outstanding balances for services rendered will be referred to a collection agency.

I have read and understand the FDHS Financial Policy, and I agree to be bound by its terms. I also understand and agree that FDHS may amend such terms from time to time.

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Signature of Patient (or Responsible Party) Date

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Please Print Name of Patient

_____ _____

Please Print Name of Responsible Party (if different from patient) Witness