Billing and Insurance Policies

Acct # ____________________

CANCELLATION POLICY

Our office has a cancellation / no-show policy in which you will be charged **$25** for failing to cancel or reschedule your office appointment 24 hours in advance. Failing to show or cancel for a scheduled surgery, e.g. colonoscopy, EGD, hernia repair, will incur a **$50** charge. Please make every attempt to call the office and notify us of any changes or emergencies that may interfere with your scheduled appointment with us. The time scheduled for your appointment is assigned to you and you alone.

FINANCIAL OBLIGATIONS

All co-payments are due when services are rendered. Deductibles and co-insurances may also be collected at this time. Outstanding balances on your account, over 45 days, may require payment before additional services are rendered.

INSURANCE CLAIM FILING

We file your insurance claims as a courtesy to you and, in most cases, provide services in good faith, prior to getting payment. If your insurance company does not respond within 60 days from the date of filing, then the balance will be transferred to you and will become the your responsibility.

PATIENT STATEMENTS

You will receive a monthly statement and payment is due upon receipt. If payment is not received, or if no response to the statement is received within 45 days, further action, including outside collection agency involvement may be taken. In the event that you have a procedure performed at Lake Surgery and Endoscopy Center or Endosurg Outpatient Center, please be advised that you will receive three separate statements:

a. **Advanced Gastroenterology and Surgery Associates*** – physician fees
b. **Lake Surgery** or **Endosurg Outpatient Center** – facility fees
c. **Anesthesia Associates** – anesthesia fees

You may also incur charges from our pathologist* if biopsies are obtained**. IF YOUR INSURANCE REQUIRES A SPECIFIC LABORATORY, YOU MUST NOTIFY THE SURGERY RECEPTIONIST.**

I request that payment of authorized Medicare/other insurance companies' benefits be made on my behalf to: **Advanced Gastroenterology and Surgery Associates, Lake Surgery and Endoscopy Center** and/or **Endosurg Outpatient Center** for any services rendered from the physicians and anesthetists associated with the above mentioned entities.

I authorize these entities to release any medical information concerning me to HCFA (Health Care Financing Administration) or any of its agents necessary to determine benefits or the benefits payable to related services.

My signature below indicates I understand and agree to the terms of service explained above. I am aware and know that I am responsible for fees associated with the cancellation policy, and all deductibles, co-insurances, and non-covered services as per my health insurance policy. I am aware that it is my responsibility to know the guidelines and limitations of my insurance policy.

____________________	____________________	__________
Print Name	Patient Signature	Date
____________________	____________________	__________
Print Name	Witness Signature	Date

Revised-JA 10/2011