PATIENT FINANCIAL POLICY

Gastro Health – Springfield

Gastro Health – Springfield is committed to providing you with the best possible care. Your understanding of our financial policy and fees is important to us. Please take time to peruse the following information. If you have any questions over our policy, please contact a member of the staff.

WE ACCEPT THE FOLLOWING MOST MAJOR INSURANCE PLANS. PLEASE CONFIRM WITH OUR OFFICE AND YOUR INSURANCE CARRIER.

WE ACCEPT THE FOLLOWING FORMS OF PAYMENT:
Cash, Check, Visa, MasterCard, Discover.

Full payment is due at the time of service unless previous arrangements have been made. If the patient is a minor, all accrued fees will be the responsibility of the parent or legal guardian. This includes all insurance co-pays.

In order for us to properly bill your carrier, please provide the office staff with necessary insurance information. In some circumstances, even participating insurance plans may leave a balance that you must pay. It is not our responsibility to know what limitations, exclusions, deductibles or co-pays each group insurance plan might leave to a patient's responsibility.

Payment Options: Under special circumstances where it has been determined you will not be able to meet your obligated portion of the office charges, please notify a member of our staff before your scheduled appointment. Gastro Health – Springfield understands that finances can be limited at times and in certain situations may extend a patient budget plan. Please understand that this payment budget is a courtesy offered by this office and not all applicants may qualify. This budget plan offer is only available to patients who don't have a primary insurance provider or are out of network. Please see our office manager for more details.

Delinquent Accounts: An account is considered past due 30 days following billing unless other arrangements have been made. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency. Please contact the billing department immediately if your account is over 30 days past due.

Tardy or Missed Appointments: Please inform the office immediately if you will be tardy for an appointment. A 24-hour notification is requested if you will be unable to keep your scheduled appointment. Gastro Health – Springfield reserves the right to charge a $15.00 missed office fee and/or $50.00 missed procedure fee for each appointment not canceled in a timely manner.

Return Check Fee: There will be a transaction fee of $15.00 for any check that is returned for insufficient funds.

***I hereby authorize Dr. Ajit and Gastro Health – Springfield to furnish information from the patient medical record and financial record to my insurer, compensation care or healthcare facility which may be providing financial assistance for my care**

***I realize the bill is my responsibility. I assign and authorize payment to be made directly to Dr. Ajit and Gastro Health – Springifeld for all insurance benefits and agree to pay any deductible amount, co-insurance, or other balance not paid by my insurance.**

***I have read the above and understand the financial policy and accept these terms. If I refuse treatment or leave the facility, I hereby release the physician of all responsibilities for my action. I may withdraw my authorization at any time by written notification to the parties' involved. A photocopy of this agreement is to be considered as valid as an original.**

Patient Signature:_____ Date: _____