Gastrointestinal Associates, LLC

Patient Financial Responsibility Form

The physicians at our office are contracted with a variety of insurance plans. We also provide services for private pay patients. We will submit claims, on your behalf, to your primary insurance carrier and one secondary insurance carrier (if applicable). Our office does not contract or file claims with **health share plans or auto and liability insurances**. Payment is required at time of service and we will provide you with an itemized statement to file for reimbursement from the insurance company.

Please remember your health insurance is an agreement between you and your insurer. It is your responsibility to know and understand the coverage, benefits and requirements of your health insurance plan. If you would like us to submit a claim for your services you must present a current insurance card at the time of service. If your health insurance requires a copay please be prepared to pay the copay at the time of service. We accept cash, check, Visa, Mastercard, Discover or American Express. If you are not prepared to pay your copay or private pay balance at the time of service, it may be necessary to reschedule your appointment.

If you have an out-patient procedure you may receive charges from the physician, facility, anesthesiologist or pathologist. Our office only has information related to the physicians' charges and, in some instances, the pathologists' charges. We can provide you with the phone numbers to contact the other offices for information regarding their charges.

Our office does not offer long term financing of balances for healthcare services we provide. Limited payment plans may be available but must be approved by our Business Office Manager. In the event your balance is not paid timely and we must employ a collection agency or attorney, all interest and/or fees for collection will be the responsibility of the patient in addition to the balance for healthcare services received.

Credit Card/Debit Card Authorization Policy

Our policy is that a credit card, debit card or HSA card information be securely stored for payment of patient balances after insurance or for private pay. There are a small number of insurance plans that are excluded from this policy. Our Registration Department will inform you if your plan meets these exclusions. If you do not wish to leave a credit card on file, we will collect, in advance, an **estimated** patient responsibility based on our contracted rate with your insurance company. This will be an **ESTIMATE** only and there may be additional charges as exact amounts cannot be determined prior to your procedure. A credit or debit card on file will be charged only if your account has a balance more than 30 days past due. If you do not provide a credit or debit card or pay an estimated patient responsibility, prior to being seen by our providers, it may be necessary to reschedule your appointment. If there is an overpayment on your account we will mail a refund check to the patient address on file. Your signature below indicates that you understand this policy.

Our business office will verify that your insurance policy is active, **for the physician only**, on scheduled procedures. This is not a guarantee of payment as your insurance company will determine payment after they receive a claim from our office. If you need more detailed policy information, you will need to contact your insurance company. After your insurance company processes your claim, Gastrointestinal Associates, LLC will mail a statement to the address on file providing you with any balance due that is your responsibility. If you have questions about your bill, you must contact the business office at **913-541-0510.**

By my signature below, I authorize Gastrointestinal Associates, LLC to securely store my credit card information and only charge it should I have an outstanding balance or any balance from a processed claim in the future. I am aware that the storage system used is fully compliant to the highest level of credit card storage security and regulations. Once stored, I am aware that only the last 4 digits of my card are viewable by Gastrointestinal Associates, LLC personnel. I understand that I am responsible for all charges for services that I receive from Gastrointestinal Associates, LLC and that if the patient responsibility portion of my charges (including charges applied to my deductible and/or coinsurance) is not paid in full within 30 days following receipt of the patient statement mailed to the address on file, Gastrointestinal Associates, LLC will charge my stored credit card for the outstanding balance due. I understand should I make a claim of fraud to charges on my credit card, as described in this policy, I will be responsible for payment of the balance for services received and all fees associated with the dispute.

I have read, understand and agree to the provisions of the Patient Financial Responsibility Form.

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Patient Name (printed) ***Patient Date of Birth***

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Signature ***Date***