

Gastrointestinal Associates, LLC
Patient Financial Responsibility Form

The physicians at our office are contracted with many insurance plans and provide services for private pay patients. We submit claims 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. Our physicians do not contract with any Medicaid plans or Medicare Advantage D-SNP plans.

Please remember it is your responsibility to know and understand the coverage, benefits and requirements of your health insurance plan. It is your responsibility to verify, with your insurance company, that you are scheduled with an in-network provider. Our office cannot guarantee your insurance policy information, or payment of a claim, as we do not have access to the details of your policy. Benefits will be determined, by your insurance company, after they receive our claim. If you would like an insurance claim submitted, you must provide the correct insurance information when speaking to registration or when you come in for your office visit. Office visit **copays** are due at the time of service. We accept cash, check, and major credit cards. 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. Our business office will verify that your insurance policy is active, **for the physician only**, on scheduled procedures. If you need more detailed policy information, you will need to contact your insurance company. Our office is compliant with the No Surprises Act. For more information please see our website **kc-gi.com** and the document titled **"Your Rights and Protections Against Surprise Medical Bills"**.

Screening colonoscopies are considered a preventative service and covered by most insurance companies at 100%. However, there are strict guidelines, set by your insurance policy, regarding what is considered a preventative screening. This includes factors such as personal and family medical history, active symptoms, or other colon cancer risk factors. Additional information is available, on our website, **kc-gi.com**. Look for the section titled **"What You Need to Know about Colonoscopy and Insurance Benefits"**.

Our office does not offer financing of balances for services we provide. Limited payment plans may be available but must be approved by our Business Office. 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.

When a patient does not notify our office of the need to cancel or reschedule an appointment, we call this a no-show. Frequent no-shows create challenges for our office when important time for patient appointments is not used. We require 24 hour notice of cancellation or need to reschedule. Failure to contact our office 24 hours prior to your appointment may result in a no-show fee of \$50.00 for an office visit or \$100.00 for a procedure.

Credit Card/Debit Card Authorization Policy

We require a credit card, debit card or HSA card information be securely stored for payment of patient balances after insurance or for private pays. 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. After your insurance company processes your claim, Gastrointestinal Assoc., LLC will send a statement either to the mailing address or email 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 Assoc, 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 understand that I am responsible for all charges for services that I receive from Gastrointestinal Assoc, 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, Gastrointestinal Assoc, 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/debit 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 all provisions of the Patient Financial Responsibility Form:

Patient name (printed)

Date of Birth

Signature

Date