Modesto Gastroenterology Medical Corporation

Payment Policy

Thank you for choosing us as your Gastroenterology specialist. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been developed this payment policy. Please read it, ask us any questions you may have, initial and sign in the space provided. A copy will be provided to you upon request.

_____ **1. Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we contract with, payment in full is expected at each visit. If you are insured by a plan we contract with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

_____ **2. Co-payments:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

_____ **3. Non-covered services:** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You will be billed for these services.

_____ **4. Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card(s) to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim.

_____ **5. Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

_____ **6. Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you.

_____ **7. Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

_____ **8. Missed appointments:**

- Office Visits: A 24-hour notice is required to cancel or reschedule all office visits. The fees for missing your appointment are:
  - New patient or consultation office appointment: **$50**
  - Established patient office appointment: **$25**
- Procedures: A 48-hour notice is required to cancel or reschedule all procedures. The fee for missing your appointment is **$100**
- After 3 missed appointments, you may be dismissed from our practice.
- These fees are charged directly to you, not your insurance company, and must be paid before rescheduling.
- If you are more than 10 minutes late for an appointment, we reserve the right to reschedule your appointment.

I have read and understood the payment policy and agree to abide by its guidelines.

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Name of patient or responsible party	*Signature*	*Date*

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