MR#_____

FLORIDA DIGESTIVE HEALTH SPECIALISTS, LLP

FINANCIAL POLICY

Our practice strives to provide optimal care, and we want to ensure you fully understand our Financial Policy.

1. Payment for all co-pays, deductibles, and outstanding patient balances is due at the time of service. We accept cash, checks, and most major credit cards. A minimum charge of $25.00 will be assessed on all returned checks.
2. Please be advised that your insurance policy is a contract between you and your insurance company.
    a. Our providers participate with many insurance companies and other health plans. Our billing department files the claims and accepts the assignment of benefits on these claims. The insurance company pays Florida Digestive Health Specialists, LLP (FDHS) directly for all claims filed by our billing service.
    b. If we do not have a contract with your insurance company, you will be required to pay for the medical services provided at the time of your visit. However, we will provide you with a summary of your visit in the form of an itemized receipt. You can submit this itemized receipt to your insurance company for reimbursement if they cover such expenses. If your insurance company approves the charges, they will pay you directly.
3. Not all insurance companies cover all services. If your insurance company determines a service to be "non-covered," you will be responsible for the entire charge. Your payment is due upon receipt of a statement from our office.
4. If you provide incorrect or false information resulting in claim denial, you are responsible for unpaid claims and service charges.
5. We will bill your insurance company for services provided to you in a hospital setting. You are responsible for any balance due if your insurance company does not pay.
6. If the undersigned fails to pay for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred, including but not limited to all reasonable collection fees and/or reasonable contingency fees added by a third party to the outstanding or referred balance.
7. We require 24-hour notice for office visits if you cannot keep your appointment for any reason. If you do not provide the required notice, your account will be charged a $50.00 no-show fee. If you do not give 72-hour notice that you are canceling your procedure(s), you will be charged a $75.00 no-show fee.
8. If the patient or responsible party fails to pay for services rendered under standard practices, such nonpayment will result in the patient/undersigned's provider and all providers of FDHS terminating their provider relationship with the patient/undersigned in accordance with applicable law. Any outstanding balances for services provided will be sent to a collection agency.

I have read and understand the FDHS Financial Policy and agree to be bound by its terms. I also understand and agree that FDHS may amend such terms occasionally.

_____ _____

Signature of Patient (or Responsible Party) Date

_____

Patient Name (Print)

_____ _____

Print Name of Responsible Party (Print) (if different from Patient) Witness