Pediatric Gastroenterology of Central Florida

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor - in other words you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement and will only require you to pay the co-payment /deductible at the time of service. We will collect the co-payment or deductible when you arrive for you appointment.
- Unless other arrangements have been made in advance by either yourself or your health coverage carrier, your co-payment is due at the time of service. For your convenience we will accept personal checks, VISA, and MasterCard. There is a $25 return check charge.
- **If you have insurance coverage with a plan with which we do not have a prior agreement**, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, **our charges for your care and treatment are due at the time of the service.**
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and we will bill you for these balances.
- For all services rendered to minor patients, we will look to the adult accompanying the patient for payment.
- **In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment. There is a $25 no-show fee if appointment is not cancelled or rescheduled at least 24 hours in advance.**

I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

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Signature of Patient or Responsible Party if a Minor Date

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Please Print the Name of the Patient