*A*ssociates in *G*astroenterology, S.C.

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Office Policies

Patient Name: D.O.B.:

As part of our commitment to offer excellent medical and professional care to you and your family, we would like to present our office payment policy in order to minimize misunderstandings about fees. Our fees are comparable with other Gastroenterologists in the Appleton area. As a courtesy, we will file all applicable office and hospital charges with your insurance/Medicare carrier(s). Providing us with accurate information at the time services are rendered will facilitate the timely filing of claims and expediting the reimbursement process. Changes in any of your information should be reported to our office in a timely manner. Your cooperation in keeping your account information current is greatly appreciated. By signing below, you authorize and request that insurance payments be made directly to ***Associates in Gastroenterology, S.C.*** ***__However, you__ are ultimately responsible for all charges***. As your physician, please remember that our relationship is with you and not your insurance company. Your benefit coverage is a contract between you and your insurance/Medicare carrier. Please be aware that not all services are covered benefits under all insurance/ Medicare contracts. Certain insurance companies (and Medicare) arbitrarily select certain services that they will not cover. We advise that you familiarize yourself with the benefits of your plan. If you have any questions about your coverage please contact your insurance company (or Medicare) directly. We ask for payment at the time of service. This includes payment for any applicable co-payments, deductibles and/or co-insurance, as determined by your insurance, each time services are rendered. We require payment at the time of check-in. We accept Cash, Checks, Master Card, or Visa. We will always work with you on your insurance(or Medicare) coverage, but the responsibility to comply with the financial and procedural steps required by your individual insurance plan(or Medicare) remains yours. If our attempts to collect any overdue balances on your account are unsuccessful and we turn your account over to a law firm or collection agency, you are responsible for any additional fees associated with this action.

If you are uninsured and are in need of care, we can see you on a self pay basis. Payment will be due at the time services are rendered with a $150.00 deposit collected prior to seeing the provider.

I authorize and consent to:

- All examination and treatment necessary for the care of the patient named below and consent to any and all procedures incident to such treatment which are deemed necessary by the physicians and clinicians of *Associates in Gastroenterology, S.C.* including, but not limited to blood and urine tests, drug tests, and any other diagnostic procedures or treatment.

- The release of all medical records to the referring and family physicians and to my insurance company (or Medicare), if applicable. I allow fax transmittal of all my medical records, if necessary.

- I authorize my insurance company (or Medicare) to pay Associates in Gastroenterology, S.C. directly for services rendered.

I have read and understand the above policies and consent to treatment.

____ Date:__________________
Signature

Printed Name:__________________________ Relationship to Patient:________________