Associates in Gastroenterology, S.C.
Dr. Nadeem Siddiqui
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Non-Network Insurance Coverage Policy

Office Visits:

Our goal is to provide you with affordable healthcare. If you have an insurance coverage which is non-network, you will be billed for all services provided, priced at full charge. However, because you have non-network insurance coverage, we will provide a discount. As a patient with non-network coverage, we offer a 30% discount for services provided in our office. Patients with non-network insurance coverage do not qualify for the 30% discount if any of the following are a factor:

- MVA - motor vehicle accidents
- PI - personal injury

New Patient Visits:

When checking in for new patient appointment, you will be asked to present a photo ID and your deposit payment of $150.00. Your deposit **will be** collected prior to seeing the provider for services rendered. The remaining balance for services rendered will be billed to you, not your non-network insurance coverage.

Follow up Visits:

When checking in for follow up appointments, you will be asked to present a photo ID and your deposit payment of $60.00. Your deposit **will be** collected prior to seeing the provider for services rendered. The remaining balance for services rendered will be billed to you, not your non-network insurance coverage.

Procedures:

Prior to scheduling a procedure performed by our providers, the estimated cost of the scheduled procedure will be provided to you at our 30% discounted rate. A 50% deposit **will be** required before any procedures will be scheduled or performed. This policy only applies to the providers at Associates in Gastroenterology and does **NOT** apply to any charges for any fees from outside facilities or any other providers (ie; anesthesiologists, imaging, pathology, labs, etc.). The deposit will need to be made in person at our office; we will accept, cash, credit or check. The remaining balance for services rendered by our providers will be billed to you, not your non-network insurance coverage.

I have read and understand the above policies and consent to treatment.
By signing below I accept responsibility for all charges for services rendered.

_____ Date: _____
Patient or Legal Representative Signature

_____ Relationship to Patient: _____
Printed Name