FLORIDA DIGESTIVE HEALTH SPECIALISTS
FINANCIAL POLICY

Our network is dedicated to providing the best possible care for you and we want you to completely understand our Financial Policy.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept most major credit cards. There will be a minimum charge of $25.00 for returned checks.

2. Please be advised that your insurance policy is basically a contract between you and your insurance company. As a service to our patients, we will file your insurance claim 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 90 days, you will be responsible for payment in full. If the practice later receives payment from your insurance, we will refund any overpayment to you.

3. We are participating providers with many insurance companies and other health plans. Prior arrangements have been made to accept assignment of benefits. We will bill your insurance for services provided; however, you are required to make your **co-payment** or pay any **deductible** at time of service.

4. If we do not participate with your insurance carrier you will be responsible for paying your charges at the time of service. We will, however, provide you with a superbill of your visit for you to submit to your insurance company. Your insurance company will then pay you directly.

5. Not all insurance plans cover all services. In the event that your insurance plan determines a service to be "not covered", you will be responsible for the entire charge. Your payment is due upon receipt of a statement from our office.

6. If you provide incorrect or false information, you will be responsible for any unpaid claims and/or all charges for services provided.

7. We will bill your insurance company for services that were provided to you in a hospital setting. If your insurance does not pay, you are responsible for any balance due.

8. 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, included but not limited to, all collection fees or contingency fees added by a third party to the original or referred balance.

9. If you cannot keep your appointment for any reason, we require 24 hours' notice for office visits. If you do not give us the required notice, your account will be charged $25.00. If you do not provide 24 hours' notice for an ultrasound appointment cancellation, your account will be charged $50.00. If you do not give 72 hours' notice that you are cancelling your procedure(s), you will be charged $75.00.

10. If the undersigned fails to pay for services rendered upon demand, then such nonpayment will result in the undersigned's provider, and all providers of the Florida Digestive Health Specialists, terminating their provider relationship with the undersigned subject to applicable law and the outstanding balance for services rendered will be referred to a collections agency.

I have read and understand the FDHS Financial Policy and I agree to be bound by it's terms. I also understand and agree that such terms may be amended by FDHS from time to time.

_____ _____

Signature of Patient (or Responsible Party) Date

_____ _____

Please Print Name of Patient Witness