Financial Policy for Gastroenterology Diagnostic Center

Cancellation Policy for Office Procedures

We at the Gastroenterology Diagnostic Center are pleased that you have chosen our facility to have your procedure. We pride ourselves in quality, cost-effective healthcare for our patients. It requires a multi-disciplinary team to have to your procedure including the anesthesiologist, endoscopy technicians and your gastroenterologist. For this reason we require **at least** a 48 hour notice for any rescheduling or cancellations. An advance notice is required so that we may accommodate our other patients. If notice is not received at least 48 hours in advance a service fee of 150.00 will be charged to you. We appreciate your cooperation in this matter.
____initial here

Insurance

As a courtesy, we will verify your benefits and file with your insurance carrier. Although we verify your benefits it is not a guarantee of payment. If your health plan determines that a service is not covered, you will be responsible for the complete charge. Payment will be due upon receipt of a statement from our office. For services rendered to minor patients, the legal guardian accompanying the patient will be responsible for payment. We strongly recommended you verify your plan benefits. ____ **initial here**

Deductibles

The business office will contact you once benefits have been verified with your insurance plan. Deductible amounts are the responsibility of the patient. Advance payment is required on procedure appointments. _____ **initial here**

Screening vs. Diagnostic Coverage

Insurance companies often provide screening benefits for routine screening colonoscopy. However, if during your screening procedure the physician removes a polyp or performs a biopsy, the procedure may be considered diagnostic and may not be covered as a screening exam. In this case, some insurance companies drop financial responsibility to the patient for all or part of the procedure cost. It is important for you to know if this may apply to your routine screening benefits. _____ i**nitial here**

I have read and understand the financial policy of Gastroenterology Diagnostic Center and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice without prior written notice.

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Signature of Patient or Legal Guardian Date

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Printed name of Above