

FINANCIAL POLICY

Thank you for choosing our practice for your gastroenterology services. We are committed to patient satisfaction and providing high quality healthcare. We value you as a patient and look forward to serving your healthcare needs. Please understand that a sound financial policy is part of every practice. The following is a statement of our financial policy.

REGISTRATION AND FINANCIAL INFORMATION

To process claims on your behalf, we must have your complete personal information, insurance coverage(s) information, your employment, and your guarantor (another individual responsible). Please bring your drivers license or other picture id on your first visit. **Please bring your current insurance card with you at every visit.** We will update and/or confirm the accuracy of this information at each office visit.

It is your responsibility to inform us in a timely manner of any changes to your billing information. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full.

REFERRALS

If your insurance company requires a **referral form or authorization**, it is your responsibility to obtain this from your primary care provider prior to your appointment. If your insurance company denies payment because there is no referral or authorization on file the balance will become your responsibility.

PAYMENT AT TIME OF SERVICE

Please be prepared to pay any co-payments, deductibles and non-covered services at the time of each visit. We will also collect all previous outstanding patient balances during check out at the end of your visit.

As a convenience to our patients, we accept cash, check (there will be a \$25.00 fee assessed for all checks returned unpaid by banks), Visa, Mastercard, Discover, and American Express.

SELF PAY

If you do not have medical insurance we offer a self pay discount. You are required to pay for services **in full** at the time of each visit.

INSURANCE

As a participating provider, we follow all mandatory guidelines as specified in each individual carrier's contract. Upon verification that we participate with your plan, we will file our charges with your carrier. With most participating contracts, we are required to collect the full "allowed" amount. (The "allowed" amount is specified by your carrier.) Therefore, you will be expected to pay your co-payment and/or deductible at the time services are rendered. Many insurance carriers have provisions in their policies resulting in non-payment of certain services. In these cases, the patient will be responsible for the non-covered charges.

In the event a procedure is necessary, we will estimate our charges, insurance company's payment, and your co-payment, and/or deductible. Your estimated co-payment and/or deductible is due prior to your procedure. (In the event of an emergency procedure you will be allowed 30 days to pay your estimated portion.) Upon payment from the carrier, you will be billed or refunded for any difference between our estimate and the actual amount due after your carrier's payment.

If we do not receive payment or rejection from your insurance company in a timely manner, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issue.

PATIENT RESPONSIBILITIES

Our providers recommend care based on the patient's best interest, which is independent of insurance coverage issues. We do our best to check benefits, eligibility, and obtain precertification, but we cannot know all of the benefits and exclusions of each patient's coverage. It is your responsibility to check with your insurance company so that you are aware of any deductibles, copays, coinsurance, or pre-existing exclusions. The patient is ultimately responsible for all charges resulting from treatment provided by Charleston Gastroenterology Specialists and Charleston Endoscopy Center.

If you have any questions about our policy, please call our Patient Accounting Dept. at 843-722-8000 x 107.

02/22/2010