Middlesex Gastroenterology Associates
Financial Policy

Patients with Insurance:

1. The patient is responsible to provide Middlesex Gastroenterology with current, accurate billing/insurance information at the time of scheduling and check-in and to notify Middlesex Gastroenterology of any changes in this information.

2. Middlesex Gastroenterology will verify insurance eligibility and obtain any necessary Authorizations prior to rendering treatment. Prior Authorization does not guarantee of payment.

3. **Co-pay, deductibles, co-insurance, previous balances and fees for non-covered services are due at the time services are rendered**. You will be responsible for all collection fees associated with the collection of your account. This is a contractual agreement between the patient and their health plan. Middlesex Gastroenterology also has a contractual agreement with the health plan to collect co-pays at the time of service and are required to report to the carrier any enrollees failing to pay the co-pay.

4. We will bill to Middlesex Gastroenterology participating insurance plans as a courtesy to our patients if the patient provides the required insurance information before the filing deadline and signs an assignment of benefits statement. All information given regarding the ability to pay, third party insurance, employments, etc will be subject to verification. Your insurance is filed as a courtesy to you. All services not paid by your insurance company will become your responsibility.

5. It is the patient's responsibility to determine whether a referral is required. The referral can be requested from your primary care physician. If you are unable to obtain the referral you will be rescheduled. If your insurance rejects, denies, or covers only a portion of treatment, the patient will be responsible for immediate payment of the balance due. If this information is available in advance a deposit may be required prior to the services rendered.

6. If you are a Medicare recipient, we will file your Medicare as required for participation in the Medicare program. If your Medicare is primary, please notify our office and Medicare of your supplemental insurance. Medicare normally forwards claims to a supplement for processing of co-insurance or deductibles. This does not guarantee your supplement will pay these balances.

7. As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. You are responsible for knowing the benefits/coverage of your insurance.

8. I request that payment of authorized benefits be made on my behalf to Middlesex Gastroenterology Associates for any services furnished to me. I give permission to Middlesex Gastroenterology Associates to release medical information pertaining to claims to my insurance carrier for services provided by them.

Uninsured Patient:

1. All charges are due and payable by the date of service.
2. All payment arrangements must be made with the Billing Office.
    - **Office Visits:** Payment Arrangements made prior to your visit are due upon arrival. Your account will be flagged with the amount due. Without payment, your visit may be rescheduled.

- **Procedures:** Payments must be made with our Billing Office prior to your procedure by phone, mail or in person. Non-payment may result in rescheduling your procedure.

3. We accept cash, checks and major credit cards. We do not accept post-dated checks.

Fee & Office Policies:

Procedure Fees are broken down and billed separately as follows:

- Professional – Physician's fee for performing the procedure
- Facility – Use of the facility
- Anesthesia
- Pathology – If biopsies are taken or polyp removed, the specimen is sent to a lab for analysis

It is the patient's responsibility to confirm deductible, copay and coinsurance amounts

If you are uninsured or have a deductible that has not been met and need to have a procedure, we require a prepayment:

- Colonoscopy - $350.00
- Upper Endoscopy - $300
- Colonoscopy & Upper Endoscopy - $500
- Sigmoidoscopy - $75.00

Last Minute Cancellation/No Show Policy:

- Failure to cancel an office visit less than 24 business hour notice will result in a last minute cancellation fee of $50.00. Failure to not show up for a scheduled appointment will result in a $50.00 no show charge. **The patient is responsible for the $50.00 fee**, this fee is not applied to any co-pay, deductible or co-insurance.

Fees/Delinquent/Unpaid Account:

- Prior to your procedure, payment of outstanding account balances will be requested and should be received unless arrangements have been made with our Billing Office.
- There is a $15.00 service charge for any co-pays, deductibles, or pre-payments that are not paid at the time of service.
- There is a $25.00 Administration Fee if you need disability/FMLA paperwork filled out.
- Any non-routine calls (prescription refills, confirming/cancelling appointments) can leave a message with the answering service. Please do not have the on-call physician paged unless you feel this is an urgent matter, doing so may result in a minimum fee of $50.00.
- If your account goes into collections, your account will be charged up to 15% of the total amount due.
- Checks returned to Middlesex Gastroenterology for insufficient funds, closed account, stopped payment or for any other reason will be subject to a $35.00 fee.

In understand that I am obligated to pay the account of Middlesex Gastroenterology Associates in accordance with the regular rates and terms of the office. I owe and agree to pay Middlesex Gastroenterology Associates for any and all charges not actually paid by insurance benefits, including those charges not covered by my insurance policy and those charges that my insurance company deems to be experimental or medically unnecessary. If my account is not paid, I will pay all court costs, attorney's fees and other costs incurred by Middlesex Gastroenterology Associates to collect the balance owed.

The undersigned certifies that he/she has read, understood and agreed to the foregoing, and is the patient or his/her representative.

Name (Please Print): _____

Signature: _____Date: _____