Digestive Disease Specialists

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FINANCIAL AGREEMENT

PRINTED NAME: _____ _____ DATE OF BIRTH: _____
FIRST LAST

TODAY'S DATE: _____

Whether signing as the patient, or patient agent, I agree that in consideration of the services to be rendered, I hereby individually obligate myself to pay the account in accordance with the regular rates and terms, in the event that my insurance company denies payment. I shall also be responsible for any office co-pay owed at the time of service. I understand that I am financially responsible for any charges as determined by my insurance carrier. I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, Digestive Disease Specialists, P.C. may disclose portions of my financial and medical records to the person or entity which is or may be liable for all or any portion of the payment(s) to Digestive Disease Specialists.

I hereby certify that the information given by me in applying for payment by insurance is correct. I understand that by signing this form, I authorize direct payment for medical/surgical services to be made to Digestive Disease Specialists, P.C.

I understand that Digestive Disease Specialists, P.C. does not accept Illinois Medicaid.

I understand that as a courtesy, Digestive Disease Specialists, P.C. will file all insurance for charges incurred. Any balance owed after all insurance payments have been received will be due 30 days after the first statement and become the responsibility of the party below. I understand that patient balances not paid within 30 days of the first statement may accrue additional charges.

I understand that a $25.00 charge will be assessed on all returned checks, including but not limited to checks returned for insufficient funds.

I understand that I may receive additional bills from separate entities related to my procedure that I am financially responsible for. These are as follows:

1. **DOCTORS FEE- This will come from Digestive Disease Specialists, P.C.**
2. **FACILITY FEE- This will come from the location where you had your procedure done.**
3. **ANESTHESIA FEE- This will come from the anesthesiologist if anesthesia is administered.**
4. **PATHOLOGY FEE- This will come from a pathologist.**

I understand that I may be scheduled for a ROUTINE SCREENING COLONOSCOPY, but the billing will depend on the findings during the procedure. If there are biopsies taken or polyps removed, the appropriate procedure code will be billed rather than a screening colonoscopy.

Cancellation/No Show Advance Notice Requirements

To provide efficient scheduling to our patients, we need to keep appointment cancellations and " no-show" activity to a minimum. To do this, we are implementing cancellation and "no-show" fees that will be charged to the patient if office visits and /or procedures are canceled without proper advance notice, or if the patient does not show up for a scheduled office visit and /or procedure.

Cancellation Notice Requirements:

Office Visit: 24-hour notice
Failure to provide the required advanced notice will result in a cancellation fee of **$25.00**

Procedure: Three business days' advance notice
Failure to provide the required advanced notice will result in a cancellation fee of **$50.00**

_____ _____
Patient Signature or Patient Guardian Today's Date

_____
Patient Print Name