

OLD TOWN ENDOSCOPY CENTER FINANCIAL POLICY

patient label

Thank you for choosing Old Town Endoscopy Center as your health care provider. We are committed to providing you the best possible care. The following information outlines some of the financial and procedural steps required by your insurance company or managed care plan.

- **Physician's charges are separate from the fee charged by the facility. You will receive a minimum of two bills: One from your physician for his/her services and one from Old Town Endoscopy Center for the use of the facility.** If a pathologist or an anesthesiologist is involved in your care, they will also bill you separately.
- You must pay any co-payments, co-insurance, and/or deductibles at the time of service, unless other arrangements have been made in advance with our office. The money required before your procedure is our best estimate which includes the portion that your insurance company does not pay. If an overpayment does occur, a prompt refund will be issued.
- Your insurance policy is a contract between you and your insurance company. Neither Old Town Endoscopy Center nor your physician can negotiate or alter that contract. Please present your insurance card at each visit. Specifically bring to our attention any changes (new card, new group number, etc.) since your last visit. We will file your claims to all applicable insurances as a courtesy to you. If we do not receive payment from your insurance(s) in a timely manner, the balance will become your responsibility. If your insurance company denies payment and we are unable to resolve the issue upon appeal, it is your responsibility to pay the denied amounts in full.
- If your insurance company remits payment directly to you in error, please forward it to us along with all paperwork sent to you. Please do not send payment back to the insurance company.

For your convenience, Old Town Endoscopy Center accepts **cash, check, debit cards, MasterCard, Visa, American Express and Discover.** We also accept CareCredit. We will be happy to assist you with a payment plan, which can be arranged prior to the day of your procedure.

I have read and understand my financial obligations. I authorize the center to release any information acquired in the course of my procedure. This release of information would be in accordance with the Federal Notice of Privacy Information. I agree that a photographic copy of this authorization shall be valid as the original. I assign the proceeds of any insurance claim to Old Town Endoscopy Center. Old Town Endoscopy Center is authorized to transfer any patient overpayment to your physician/Digestive Health Management, if an outstanding balance exists. I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company, as applicable by state and/or federal law. I understand that without my signature, my insurance cannot be filed nor can any reports be released to my referring physician. I have received the Notice of Privacy Practices Information.

We value you as a patient. Our first priority is to provide you with quality, cost effective medical care. If you have any questions or concerns, please feel free to contact our billing office, you may reach them at 214-689-3829 or 800-425-3759.

NAME

DATE