



GASTROENTEROLOGY HEALTH PARTNERS, PLLC

PATIENT FINANCIAL POLICY

Thank you for choosing Gastroenterology Health Partners, PLLC as your health care provider. Please understand that payment of your bill is considered a part of your treatment. We welcome the opportunity to discuss any aspect of our Financial Policy with you or your legal/authorized representative.

INSURANCE: Your insurance coverage is a contract between you and your insurance company, and it is important that you understand the provisions of your policy. If you are covered by any private insurance carrier or government sponsored program, you must present your current insurance card and photo ID prior to services being rendered. If your card is not available, your appointment will be rescheduled.

Although Gastroenterology Health Partners, PLLC will file an insurance claim as a courtesy on your behalf, it cannot guarantee payment of claims and it cannot accept responsibility for collecting payment or for negotiating settlement on a disputed claim. A reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation; professional services are rendered and charged to the patient, not the insurance company. You, the patient, are responsible for payment in full on all services rendered. You must verify whether your insurance plan requires a referral and/or authorization services, and it is your responsibility to obtain the referral and/or authorization. Your appointment will be rescheduled should a referral and/or authorization not be obtained prior to your appointment date. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, the policyholder. Not all services are a covered benefit in all insurance plans.

COPAYMENTS, DEDUCTIBLES, & NON-COVERED SERVICES: All copayments, deductibles, and payment for non-covered services are due at the time services are rendered. Please bring a method of payment in preparation for your appointment. If Gastroenterology Health Partners, PLLC does not participate with your insurance plan or if you do not have health insurance coverage, payment in full is due at the time all services are rendered.

COMMUNICATION: Communication regarding your account may be necessary to ensure your account remains in good standing. The undersigned provides authorization to receive communication regarding his/her account from Gastroenterology Health Partners, PLLC, its affiliates, and/or business partners through multiple methods to include, but not limited to, postal mail, voice call, call via auto-dialer, pre-recorded voice messages, SMS messages, and email to any landline phone, cell phone, or email address provided.

NON-PAYMENT & ACCOUNTS REFERRED TO COLLECTIONS: If your account becomes delinquent and you have not responded to our collection efforts, your account will be turned over to an outside source for collecting the full balance due, and at which time you will be responsible for all additional fees related to that expense, including all applicable court costs and legal fees; these fees will be in addition to the any existing overdue balance. Non-payment of your bill may lead to dismissal from the practice. If you cannot pay your balance in full, we encourage you to contact our billing team at 812-206-7093 for payment assistance.

RETURNED CHECKS: All returned checks are subject to a service fee. Returned check fee(s) must be paid in full prior to scheduling future appointments.

MISSED APPOINTMENTS: If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance. This allows us time to offer another patient an opportunity to be seen. It is also important to be on time for your appointment and to arrive early to complete any necessary paperwork. **Please note that a 24-hour notice is required prior to cancelling and/or rescheduling an appointment. A \$25.00 fee will be incurred for appointments which are not cancelled and/or rescheduled at least 24 hours in advance. Procedure appointments which are not cancelled or rescheduled at least 48 hours in advance will incur a \$100.00 charge.** Cancellation charges are not covered or paid by any insurance company, and therefore, charges will be billed directly to the patient. All cancellation fee(s) must be paid in full prior to scheduling future appointments.

MINOR AGE PATIENTS: Treatment for unaccompanied minors will be denied unless charges have been pre-authorized prior to date of service. Parents, guardians and adults accompanying a minor are responsible for payment in full.



WORKMAN’S COMPENSATION, AUTOMOBILE ACCIDENTS: Full payment is due at time of service. Although claims for these services will NOT be filed on your behalf, we will provide you with any information that you may need to file a claim for services on your own.

DISABILITY FORMS: Disability, FMLA, Life Insurance and other forms often require review and completion of detailed medical history by our clinicians. Please allow 5-7 days for completion of these forms. Additional fees apply for completion and payment must be made in full upon submission to our office.

MEDICAL RECORDS REQUESTS: Requests for copies of medical records will be processed upon receipt of a completed Medical Records Request Form. Any applicable fees must be paid prior to processing. Per Kentucky state law, there is no charge for the first requested copy for Kentucky patients. Please allow us (5) business days to complete all requests. Per Indiana State law, an additional \$10.00 rush fee will be assessed for requests needed within (2) business days and a \$20.00 fee for certification of records.

FEES:

ITEM	FEE
FMLA, Disability, and Miscellaneous Forms	\$35.00
Missed Office Appointment - Fee assessed if appointment not cancelled within 24 hours	\$25.00
Missed Procedure Appointment	\$100.00
Returned Checks	\$30.00
Medical Records Release - Electronic copies provided for personal health record	No Charge
Medical Records Release - Paper copies	
Pages 1-10	\$1.00/page
Pages 11-50	\$0.50/page
Pages 51+	\$0.25/page

AFFILIATIONS: You may receive statements from multiple entities after having a procedure. Although the physicians of Gastroenterology Health Partners, PLLC may have shareholder interest in external procedure centers, you may receive separate statements for fees associated with professional services, facility, pathology, infusion services, or other diagnostic testing. If you have a procedure performed by any of our physicians at an ambulatory surgical center or a hospital, you will receive a bill from that facility for its facility fee as well as from Gastroenterology Health Partners, PLLC for professional and ancillary services which apply.

I have received, reviewed and understand the Gastroenterology Health Partners, PLLC financial policy and I agree to be bound by each of its terms and conditions. I also understand and agree that such terms may be amended by the practice from time to time. I understand that I am financially responsible for all charges regardless of payments made by my insurance. I hereby authorize Gastroenterology Health Partners, PLLC to release medical information to my insurance company to secure payment of benefits. I also authorize the use of this signature on all insurance submissions and as authorization for payments to be sent to Gastroenterology Health Partners, PLLC. This signature authorizes release of medical records to any physicians or health care facility when referred or requested by them for continuity of care. I voluntarily consent to medical care including the routing of diagnostic testing, surgical procedures and additional medical treatment.

Patient Name (please print)

Relationship

Patient Signature (or Responsible Party)

Date