New Patient Form

Financial Policy: Page 1

Thank you for choosing Arizona Digestive Health as your healthcare provider. Our goals are to provide you with excellent gastroenterology care, minimize your out-of-pocket expenses and make paying your balance as easy as possible. Our financial department is dedicated to informing you, to the best of our ability, of your estimated portion of the charges for your care and assisting you with any billing questions you may have.

INSURANCE: For the patient's convenience, we file medical claims with insurance plans with which we have an agreement, as long as valid insurance information is provided to us. It is the responsibility of the patient to make accurate and detailed insurance information available to us to enable processing of his or her insurance claim. The patient is to be considered self-pay until this information is provided to us. The patient is responsible for notifying our office of any insurance changes prior to scheduled appointments. Insurance policies are an agreement between the patient and his or her insurance company. All account balances are the responsibility of the patient. Payment is due from the patient upon receipt of the first statement from our office.

The patient is expected to know his or her insurance benefits, including deductible and co-payments. Co-payments and deductibles are to be paid at the time of service. If the patient does not have medical insurance, or if Arizona Digestive Health is not a participating provider with his or her insurance carrier, all charges incurred during treatment are due and payable at the time of service. If the patient's deductible or co-payment exceeds $500.00 we will contact him or her for a deposit prior to the service being rendered.

ALL CHECKS RETURNED FOR NON-SUFFICIENT FUNDS WILL BE ASSESSED A $35.00 CHARGE.

REFERRALS/AUTHORIZATIONS: It is the responsibility of the patient to obtain a referral from his or her primary care physician prior to the scheduled visit if a referral is required by insurance to obtain services provided by a specialty provider. If a referral is not obtained, the patient accepts full financial responsibility for all services rendered. CANCELLATIONS/FEES: If the patient is unable to keep a scheduled appointment or procedure, it is his or her responsibility to notify our office at least 24-hours prior to the scheduled appointment or 48-hours prior to the scheduled procedure. Appointments cancelled after this timeframe may be subject to a cancellation fee. Additional fees may also be applied to requests for medical records and for physicians completing paperwork for patients (i.e. Disability, FMLA forms). These fees are not covered by insurance and the patient accepts full financial responsibility for all additional fees.

TELEPHONE CONSUMER PROTECTION ACT (TCPA): I agree that Arizona Digestive Health or any other collection or servicing agency or agencies retained by Arizona Digestive Health (together referred to hereafter as "collectors") to collect any money that I owe to Arizona Digestive Health may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages, or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to Arizona Digestive Health or otherwise associated with my account.

Continue On Next Page

RELEASE OF INFORMATION: I hereby authorize Arizona Digestive Health to release information to my insurance company with regard to all treatment as is necessary to obtain payment for services and to review activity related to the provider's participation with my insurance plan. I assign all benefits, to which the patient or insured is entitled for my treatment and medical services provided to me, to be paid directly to Arizona Digestive Health, P.C. I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance. I acknowledge I am bound to pay for services rendered, including all costs of collection and reasonable legal fees should collection become necessary. I have read and understand this Financial Policy, and by signing am in agreement and accept all terms and conditions described above.

_____

Patient Name (please print)

_____ Date: _____

Signature of Patient or Patient Representative