

SALEEBY AND WESSELS PROCTOLOGY FINANCIAL POLICY FORM

Patient Name _____ Date of Birth _____

This form is to outline our policy regarding payment for services. Please take the time to read it carefully. We will be happy to answer any questions you may have. Payment for service is due at the time service is provided in our office including, all copayments and deductibles. We accept **cash, checks, Visa and MasterCard**. You must bring your **insurance card** including any **Medicare** and **Medicaid** cards and your **driver's license** to your appointment.

For patients with Insurance: We bill most insurance carriers for you if proper and complete paperwork is provided to us **prior** to services being rendered. Incomplete information may result in claim denial which you would then be financially responsible for. If your plan requires a referral from your primary care physician, you are responsible for obtaining this prior to being seen. Failure to do so may result in claim denial which you will be financially responsible for. Prior to scheduled surgeries or colonoscopies, we will provide an estimate of our fees for the services, please note that this is neither a guarantee of payment by your insurance company nor an accurate reflection of your actual costs including copayments or deductibles as determined by your insurance carrier upon processing of your claims. Furthermore, prior authorization may be required by your carrier. If your plan has a high deductible, you will be asked to make a deposit prior to the procedure. In the event that your insurance carrier does not pay on your charges at the estimated rate or within a reasonable period of time upon request of this office, you will be responsible for the full balance due on the account. This includes all costs associated with collection efforts including but not limited to collection agencies, legal and attorney fees.

For patients with Medicare: We will bill Medicare for you. All copayments and deductibles are due at the time of service. In the case of services not typically covered by Medicare, you will be given the option to receive care at additional cost to you if Medicare denies your claim. This is outlined in the Medicare Advanced Beneficiary Notice which you must sign.

For patients with Medicaid: We will bill Medicaid for you. All coverage information must be complete and correct.

For self pay patients: Payment for service is due at the time of service. We can provide an estimate of our fees prior to services in the office. This is only an estimate and the actual amount may be higher or lower. Prior to scheduled surgeries or colonoscopies, we will provide an estimate of our fees for the services, please note that this is only an estimate and that your actual costs may be higher. Additionally, this estimate does not include the costs of the facility (hospital or ambulatory center) or the anesthesia, and you will be required to make payment arrangements for these services separately from this office. All surgeries and colonoscopies require a deposit upon scheduling.

I have read, understand and agree to the above financial policy for payment of fees. I agree to pay the balance owed on my account including costs associated with collection efforts. I understand that the patient is ultimately responsible for all professional fees.

Signature of Patient

Date

Signature of Guarantor if different from above

and Relationship to Patient

Date