

WESTSIDE GASTROENTEROLOGY

FINANCIAL POLICY

WE ARE COMMITTED TO MEETING YOUR HEALTHCARE NEEDS. OUR GOAL IS TO KEEP YOUR INSURANCE OR OTHER FINANCIAL ARRANGEMENTS AS SIMPLE AS POSSIBLE. IN ORDER TO ACCOMPLISH THIS IN A COST-EFFECTIVE MANNER, WE ASK THAT YOU ADHERE TO THE FOLLOWING GUIDELINES:

- 1). PAYMENT IS EXPECTED AT THE TIME OF SERVICE, THIS INCLUDES CO-PAYS, DEDUCTABLES, PERCENTAGES AND SELF-PAY PATIENTS.
- 2). WE WILL FILE YOUR INSURANCE FOR YOU IF WE ARE A PARTICIPATING PROVIDER ON YOUR PLAN. YOU WILL BE RESPONSIBLE FOR ANY AND ALL SERVICES IN EXCESS OF YOUR INSURANCE LIMITS AS WELL AS ALL NON-COVERED SERVICES.
- 3). IF WE ARE NOT PARTICIPATING PROVIDERS OF YOUR PLAN, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE WILL GIVE YOU COMPLETE FORMS THAT WILL BE ACCEPTED BY YOUR INSURANCE COMPANY FOR REIMBURSEMENT.
- 4). WE WILL MAIL TO YOU A MONTHLY BILLING STATEMENT FOR ANY OUTSTANDING BALANCES.
- 5). ALL OUTSTANDING BALANCES GREATER THAN (30) DAYS WILL BE TRANSFERRED TO AN OUTSIDE COLLECTION AGENCY AND/OR LAW FIRM TO COLLECT THE AMOUNT DUE, WHICH IS TO INCLUDE BUT NOT LIMITED TO A FEE OF \$20.00 AND POSSIBLE OTHER ADDITIONAL FEES.

I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND ACCEPT THIS FINANCIAL POLICY.

PRINTED NAME

_____/_____/_____
DATE

SIGNATURE

New policy as of 1/2008