KANSAS GASTROENTEROLOGY

Office Use Only

Patient Name _____

ID#:_____ **Physician #:**_____ **Date:** _____

Financial Policy

The following is a statement of our Financial Policy which we request that you read and sign as your acknowledgement and understanding.

Kansas Gastroenterology, LLC (KSG) is committed to providing quality care for our patients. Our charges are considered to be usual and customary for our area.

Co-pays/Coinsurance/Deductibles

As you check in for your visit we will collect your copay, coinsurance, and/or deductible. We accept cash, check, visa or mastercard.

Insurance

As a courtesy to our patients, we will file your Primary and Secondary insurance that you have provided at the time of your visit. In order to properly bill your insurance company we require that you disclose all necessary information required to file your insurance. This includes any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the visit. Although we may estimate the payment from your insurance company, it is the insurance company that determines the final payment based on your eligibility and benefits.

Should you not have insurance coverage, you will be responsible for paying your balance in full at the time of the visit.

Referrals and Preauthorizations

You are responsible for obtaining a referral and/or preauthorization from your insurance company should it be required for any services you may receive at KSG or from any of their providers. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company. By signing below, you understand that the amount of the visit will become your responsibility.

Cancellations or Missed Appointments

We require 24-hour notice for appointment cancellations. Appointments scheduled for a clinic visit may be charged a fee of $30.00 if missed or not previously cancelled 24 hours prior to the visit. Appointments scheduled for a procedure (Colonoscopy, EGD, Flexible Sigmoidoscopy, etc) at Kansas Endoscopy or other outside facility may be charged a fee of $100.00 if missed or not previously cancelled within 24 hours of the scheduled procedure.

Infusion Copay Programs

Infusion Copay Programs are services which provide funds to qualifying patients on their infusions (medication only). Patients enrolled in such a program grant permission to Kansas Gastroenterology, LLC to keep a copy of the card on file and apply any credits from the program to the card.

By signing below, you understand this financial policy including your responsibility for timely payment of the account. You will receive a statement for services which are due and payable upon receipt. KSG accepts cash, check, Visa, MasterCard and Discover. If timely payment is not received, the account may be sent to an outside collection agency or attorney. This may result in the unfortunate dismissal from the practice.

If a check is returned from the bank due to insufficient funds, a $35.00 charge will be applied to your account. You may be placed on a cash only basis following any returned check.

I have read the Financial Policy. I understand and agree to this policy.

X _____Date _____

Signature of Patient or Responsible Party

_____

Patient Name (Printed)

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.