

Patient Financial Statement & Acknowledgement

PATIENT NAME: _____

DATE: _____

DATE OF BIRTH: _____

Thank you for choosing Great Lakes Gastroenterology 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. Please review the following information as it details your patient financial responsibilities.

INSURANCE:

- Insurance coverage is a contract between you and your insurance company. Patients must understand policy provisions.
- Patients using a private insurance carrier or government sponsored program must present current insurance cards and photo ID prior to services being rendered.
- Great Lake Gastroenterology will file an insurance claim as a courtesy on each patient's behalf, but cannot guarantee payment of claims, accept responsibility for collecting payment or for negotiating settlement on a disputed claim.
 - A reduction or rejection of your claim by the insurance company does not relieve patients of financial obligation.
 - Professional services are rendered and charged to the patient, not the insurance company. Patients are responsible for payment in full on all services rendered.
- Needs for referrals and/or authorization services related to their current appointment must be verified by patients with their insurance plans.
 - Appointments will be rescheduled should a referral and/or authorization not be obtained prior to the patient's appointment date.
- If a patient's insurance company pays only a portion of the bill or rejects the claim, any contact or explanation should be made to the patient who is 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.
 - Great Lakes Gastroenterology does not wave copayments, deductibles, or other patient balances.
- If Great Lakes Gastroenterology does not participate with a patient's insurance plan or if the patient does not have health insurance coverage, payment in full is due at the time all services are rendered.
 - If a patient is unable to pay required co-pay, deductible or any self-pay fees, the appointment may be rescheduled.

COMMUNICATION:

- Communication regarding a patient's account may be necessary to ensure the account remains in good standing.
- The undersigned provides authorization to receive communication regarding his/her account from Great Lakes Gastroenterology, 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 a patient account becomes delinquent and the patient has not responded to our collection efforts, the account will be turned over to an outside source for collecting the full balance due:
 - Patient will be responsible for all additional fees related to that expense (i.e., applicable court costs and legal fees).
 - These fees will be in addition to the any existing overdue balance.
 - We encourage patients to contact our billing team at 440-205-1225 for payment assistance.
 - A patient's failure to pay off a balance or to initiate a payment plan may lead to the patient's dismissal from the practice.

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:

Great Lakes is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Office Telehealth Appointments

- Patients unable to keep a scheduled office or telehealth appointment must notify us at least 24 hours in advance to cancel and/or reschedule the appointment. This notification allows us time to offer another patient an opportunity to be seen.
- Patients must make every effort to be on time for appointments and to arrive early to complete any necessary paperwork.
- **A \$50.00 fee will be incurred for office/telehealth appointments not cancelled and/or rescheduled at least by 2pm the day prior to your scheduled appointment. To cancel your Monday appointment, please call by 2pm on Friday.**
- After you have had 3 late notice cancelations or no-shows, you may be discharged from the practice.

Procedure Appointments

- **Procedure appointments not cancelled or rescheduled at least 72 hours in advance will incur a \$250.00 charge.**
- Cancellation charges are not covered or paid by any insurance company and will be billed directly to the patient.
 - All cancellation fee(s) must be paid in full prior to scheduling future appointments.
- **If you No Show for your scheduled procedure, you will need to pay the \$250.00 charge, along with having to see your physician in the office or by telehealth prior to rescheduling your procedure.** If you No Show for more than one procedure, you may be discharged from the practice.

AFFILIATIONS:

- Great Lakes Gastroenterology is affiliated with Dayton Gastroenterology. You may see this business name on your insurance Explanation of Benefits.
- Patients may receive statements from multiple entities after having a procedure.
- Although the physicians of Great Lakes Gastroenterology may have shareholder interest in external procedure centers, patients may receive separate statements for fees associated with professional services, facility, pathology, infusion services, or other diagnostic testing.
- If a patient has a procedure performed by any of our physicians at an ambulatory surgical center or a hospital, the patient will receive a bill from that facility for its facility fee as well as from Great Lakes Gastroenterology for applicable professional and ancillary services.

PATIENT ACKNOWLEDGEMENT:

I have received, reviewed, and understand the Great Lakes Gastroenterology 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 Great Lakes Gastroenterology 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 Great Lakes Gastroenterology. 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)

DATE OF BIRTH

PATIENT SIGNATURE (or Responsible Party & Relationship)

DATE