OFFICE POLICIES

Welcome to our office and thank you for choosing Pediatric Gastroenterology Associates for your care. Our goal is to provide you with excellent quality medical care. We have developed the following policies because we believe your clear understanding is very important to our professional relationship.

Patient Name: _____

CO-PAYMENTS:
Co-payments are due and collected on the day of your appointment. You may use the credit card on file option.

INSURANCE REFERRAL POLICY:
If my insurance plan requires a referral, I understand that it is my responsibility to obtain an updated referral from my Primary Care Provider and to make sure that *Pediatric Gastroenterology Associates* has the referral before my visit. I further understand that it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referral and to obtain new ones as needed. If no referral is obtained and I want to be seen by the provider, I will be responsible for paying for my visit. If the referral information the office has at the time of my visit is not correct, I will be responsible for all charges.

INSURANCE POLICY:
It is the patient's responsibility to know the limits and coverage of your particular health insurance policy. We will make clinical recommendations that we think are in your best interest of the patients, but we cannot guarantee that your policy will cover any and all charges incurred. At the time of each visit we require you to confirm your current insurance status and any change in the insurance information must be provided with a valid insurance card or temporary print out to the front office staff. Should you be unable to produce this documentation, you may pay in full at the time of service and submit the claim to your insurance carrier for reimbursement. If both parents carry health insurance for the patient, please check your insurance companies to determine which policy is primary prior to your appointment.

If my insurance does not cover a service for any reason that was performed, I am responsible for paying these charges. _____(initials)

I understand that by signing below I am responsible for notifying our office of any changes to my insurance or contact information. _____ (initials)

If the insurance I present is not valid or the office is not in my network, I am responsible for all charges. _____ (initials)

ACCOUNT BALANCE:
All account balances are due in full upon receipt of your 1st statement, if your balance is left unpaid after 30 days, there will be a $10/- billing charge added for each billing cycle. Any balance left unpaid after 60 days, without a practice authorized payment plan, will be considered delinquent and may be submitted to a collection agency. Submission of your account to a collection agency my adversely affect your credit score and interfere with our ability to get credit. If you present a check that cannot be cashed for any reason, you are responsible for the balance and all bank/office fees charged.
For our patients convenience we offer the option of ***credit card on file***, which can be helpful in making your payments in a timely and safe manner, on a flexible and recurring payment plan.

MINOR PATIENTS:
A legal guardian must accompany children under the age of 18 to all appointments.
If you are a college student on your parent's insurance plan, your insurance company will require a form to be completed confirming your student status. These forms are mailed to your home address and must be completed and returned within 30 days. If these forms are not returned within the time frame, you will be financially responsible for all charges.

Patient/Guardian Name: _____

Signature: _____ ***Today's Date:*** _____