OCEAN FAMILY GASTROENTEROLOGY

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Thank you for choosing Ocean Family Gastroenterology for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our financial policies.

PATIENT FINANCIAL RESPONSIBILITIES

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment or care.
- If your insurance requires a referral, it is the patient's responsibility to obtain the referral and present it at their office visit. If a visit/procedure is denied due to no referral, the patient is responsible for payment.
- We will bill your insurance for you. However, the patient is required to provide the most current updated information regarding insurance.
- Patients are responsible for payment of copays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan.
- Co-pays are due at the time of service.
- Co-insurance, deductibles and non-covered services are due 30 days from the receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable.
- Kindly give at least a twenty four hour notice prior to cancelling an appointment to avoid a late cancellation fee of $25.00, if the appointment slot is unable to be filled.

EFFECTIVE 8/1/17

NO SHOW APPOINTMENT FEE:	**$50.00**
RETURNED CHECKS CHARGE:	**$35.00**
NO SHOW PROCEDURE FEE:	**$100.00**

By my signature below, I hereby authorize assignment of financial benefits directly to Ocean Family Gastroenterology. I understand that I am financially responsible for charges not covered by this assignment.

_____ _____

Print Date

_____

Signature