

FINANCIAL POLICY

Thank you for choosing us as your health care provider. Acadiana Gastroenterology Associates, LLC and Acadiana Endoscopy Center, Inc. are committed to making healthcare less stressful and more effective by clarifying financial responsibilities in advance. The following is a statement of our financial policy which we ask that you **read and sign where indicated below** prior to your initial office visit or procedure.

INSURANCE AND PAYMENT POLICY: Your insurance policy is a contract between you and your insurance company.
OFFICE VISITS: It is very important that you contact your insurance prior to the initial office visit in order to assure that the attending Physician is covered on your plan or participating within your insurance's network. By doing so, your insurance will inform you if a referral is required or if there are any out of pocket expenses such as co-pays, co-insurance or deductibles. We are not a party of that contract.
PROCEDURES: As a courtesy, the attending Physician's office obtains pre-certification (if necessary) for procedures at our Facility – Acadiana Endoscopy Center, Inc. Pre-certification of your procedure does not guarantee payment for services provided. **It is the patient's responsibility to verify benefits with his / her insurance**, determine if the scheduled procedure is a covered service, and to know the extent of his or her coverage(s) for services provided by the attending Physician and the Facility.

Filing your insurance is a **COURTESY ONLY**. Our office policy allows 45 days for insurance payment. Please note: After 45 days, you are responsible for the bill regardless of what the status is of the insurance. Payment arrangements should be made with our office prior to your scheduled procedure. All outstanding patient balances over 120 days from the original date of service without payment arrangements made will be turned over to a collections agency. If **MEDICARE / CMS** is your primary insurance, we will file all claims and accept assignment for related services. Any **deductibles and/or co-insurance are due and payable at the time of service**.

PAYMENT METHODS: We accept payment in the forms of cash, check, Discover, Visa, MasterCard and American Express credit cards. **There will be a \$25.00 fee for all returned checks.** 'Self Pay' patients are required to pay - or make payment arrangements - for covering the estimated charges prior to any scheduled procedure.

BILLING STATEMENTS (Physician, Facility, Pathology and Anesthesia fees): If you will be having a procedure performed by one of the Physicians of Acadiana Gastroenterology Associates, please be aware that **YOU WILL RECEIVE SEPARATE BILLING STATEMENTS** for other services provided depending on where your procedure is performed. You will receive a statement from **Acadiana Gastroenterology Associates, LLC** for the Physician's professional services. If your procedure is performed at **Acadiana Endoscopy Center, Inc.**, you will receive a statement for Facility charges billed by Acadiana Endoscopy Center, Inc. You may also receive a statement from **Inform Diagnostics** for pathology services if biopsies (tissue specimens) or polyps are removed during your procedure. Depending upon your sedation plan, you may also incur an anesthesia charge from **Precision Anesthesia of Lafayette, LLC** for IV anesthesia services provided. If your procedure is scheduled and performed in a hospital setting, you will receive similar statements but from other service providers. If you have any questions, please call before your scheduled visit or ask any of our front office staff on the day of your appointment.

SCREENING COLONOSCOPY VS. DIAGNOSTIC COLONOSCOPY COVERAGE: Insurance companies will often provide **SCREENING BENEFITS** for routine screening colonoscopy. However, if the Physician removes a polyp or performs biopsy during your screening procedure, the procedure may be considered 'diagnostic' and may not be covered as a screening exam. If this were to occur, some insurance companies make the patient financially responsible for all or part of the procedure cost. Please refer to your individual policy terms, conditions, and coverage regarding these benefits.

CANCELLATION POLICY – ACADIANA ENDOSCOPY CENTER, INC: Your time and care is very important to us. In order for our Facility to provide exceptional care and accommodate the needs of our patients as efficiently as possible, certain 'block-time' requirements have been established for each patient's procedure type. Therefore, we require sufficient notice in the event of a cancellation and / or rescheduling of a procedure in order that we may accommodate other patient's needs. Please note: The Facility of Acadiana Endoscopy Center, Inc. requires a **3 day notice (Three Business Days) for cancellations of all procedures.** **Acadiana Endoscopy Center, Inc. will assess a \$100.00 'late cancellation' fee** towards the patient's account if notice is not received before the 3 business day limit. This fee will not be covered by your insurance company. Therefore, the fee will be billed directly to the patient. We ask that you or a family member call our Center at (337) 269-1126 between the hours of 7:00 am – 2:00 pm, Monday through Friday, for cancellations or to reschedule your procedure.

ACKNOWLEDGEMENT: I hereby authorize Acadiana Endoscopy Center, Inc. and Acadiana Gastroenterology Associates, LLC to furnish information to my insurance company concerning my illness and treatment for payment purposes. I hereby assign Acadiana Endoscopy Center, Inc. and Acadiana Gastroenterology Associates, LLC all payments for medical services rendered to myself or dependents. I understand that I am responsible for all charges for services rendered regardless of insurance coverage.

Signature of Patient / Acknowledgement (or Parent if Patient is a minor)

Date:

Printed Name of Patient