OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered to be part of your treatment arrangement. The following is our Financial Policy, which we require you to read prior to any treatment.

All patients must complete our Registration and History forms before seeing the doctor. You must supply us with both your insurance card and driver's license prior to your visit.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, AND ALL MAJOR CREDIT CARDS.

Statement of Financial Responsibility
I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all the expenses incurred.

Notice of "Non-Covered" Services
I am aware that some services performed by Gastro Florida may be considered "non-covered" by my insurance carrier or Medicare, therefore I will become fully responsible for payment of these services.

For patients with "Out-of-Network" coverage there is a Waiver of "Usual, Customary and Reasonable" Clause. I acknowledge that the fee charged by Gastro Florida for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fee considered "usual, customary and reasonable", due to specialized services and staff. However, I agree to pay Gastro Florida fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

Missed Appointments
Unless canceled at least 48 hours in advance, our policy is to charge for missed appointments. The current rate is $50.00.

Procedures
We will ask that you pay 100% of any outstanding deductible/co-insurance prior to your procedure. This is due no later than 3 days prior to your procedure. Any refunds due to you will be sent 7-10 days after you have incurred the refund.

Bill To/Payment Instructions

_____ Commercial Insurance/Third Party Payor _____ Medicare _____Medicaid
Initial Initial Initial

I hereby authorize Gastro Florida to bill my insurance company and/or Medicare (indicated or initialed above) for services provided to me and request that payment for such services be made to Gastro Florida on my behalf.

List Names of Those Whom You Want Us to Share Your Financial Responsibility Information:

Name: Relationship:

_____ _____

_____ _____

Financial Agreement
The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the service to be rendered to the patient, he/she obligates himself/herself to pay the account with Gastro Florida in accordance with the regular rates and terms of Gastro Florida. Should the account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay reasonable collection and attorney fees for collection expenses.

Billing Questions
Please address all billing questions to our Central Business Office (727) 347-0005.

Payment Plans
You can call our Central Business Office to determine if you qualify for this arrangement.

Patient Name: _____ Patient Signature:_____
(please print)

Legal Guardian:_____ Guardian Signature _____
(please print)

_____ _____
Witness Date