PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.
FINANCIAL POLICY

PATIENT INFORMATION		
Name:	Date of Birth:	Today's date:

Thank you for choosing us as your health care provider. We are committed to providing you the best possible medical care. Please understand that payment of your bill is important. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Regarding Insurance:
As a courtesy our office will bill your insurance for the services you will receive. We cannot bill your insurance company unless you give us correct insurance information. **It is your responsibility to inform us if your insurance has changed at any time during treatment**. Please understand that your bill is ultimately your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full in a timely manner, it will then become your responsibility to pay the balance. We accept Cash, Check, Visa and MasterCard. You will be charged a $25 fee for any returned check. Any account over 90 days old without payment is subject to being sent to a collection agency.

**All co-pays are due at the time of visit. Deductibles are due prior to procedure.

Credit card on file for remaining balance:
We require your credit card information (Visa or MasterCard) for any remaining balance which is not covered by your health insurance. Your signature on file is to permit us to charge your credit card up to $100. For any balance exceeding $100, we will call you for your permission to charge your credit card; or if you wish, you could still pay by cash or check.

Referrals and Pre-authorization:
If your insurance company requires a referral from your primary care physician, you must present this to our staff before being seen. If you do not obtain a referral when your insurance company requires one, you will be required to pay in full for the visit or service. It is your responsibility to obtain a referral.

Missed Appointments and Cancellation Fee:
Due to the amount of time allotted for scheduled endoscopic procedures, we do request at least 3 working days notice for cancellation of any procedures. **It is our policy to charge a $100.00 cancellation fee if given less than 3 working days notice.** The charge for a late cancellation/no show for procedure will be billed directly to you and not to your insurance. Please help us serve you better by keeping scheduled appointments.

Ancillary Services:
Please be aware that there may be a charge involved for ancillary services such as completing disability forms and/or forms related to your care, and drafting letters on your behalf. A $10 copying and handling fee is charged for providing medical records to you.

Patient Balances/Late Fee:
If payment is not received within 30 days of the statement, a $10.00 late fee each month will be applied to your balance until full payment is received.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I authorize Om P. Chaurasia, M. D., Inc. dba Pacific Gastroenterology Medical Associates, Inc. or my insurance company to release any information required for processing my insurance claim. I also authorize my insurance benefits to be paid directly to the physician.

I have read the Financial Policy in full and I understand and agree to this policy.

_____ _____
Signature of Patient/Guardian Date