MILFORD GASTROENTEROLOGY ASSOCIATES, INC.

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FINANCIAL POLICY

Thank you for choosing Milford GI Associates as your health care provider. We are all concerned about the rising cost of health care, and we are committed to providing you and your family with the highest quality and affordable health care. The following is a summary of our financial policy.

1. **Insurance**. We participate in most insurance plans, including Medicare. We must obtain a copy of your current card in order to bill on your behalf. If you fail to provide us with correct insurance information, you will be responsible for your bill. It is your responsibility to know your benefits. Please contact your insurance company directly with any questions you may have regarding your coverage.
2. **Copayments**. All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company.
3. **Referrals and authorizations**. If your insurance company requires a referral from your primary care physician (PCP), it is your responsibility to obtain one. If a valid referral is not on file, you will be responsible for payment in full at the time of service. It is your responsibility to verify that your PCP is listed correctly with your insurance company. If the PCP is not correct at the time of service, you will be responsible to pay for the services rendered.
4. **Non-covered services**. Please be aware that in unusual cases, some of the services you receive may not be covered by your insurance. Milford GI Associates adheres to a policy of providing high quality, medically appropriate care for our patients. We do not utilize insurance coverage limitations as a prime factor in the medical decisions of your treatment. If non-covered services are required, payment in full for these services will be expected. We encourage you to check with your insurer if there are questions concerning your coverage for services.
5. **Non-payment**. If your account is past due, we may refer your account to a collection agency, and you may be discharged from this practice.
6. **Returned checks**. Checks returned by the bank will be assessed a $25 processing fee. These charges will be your responsibility and billed directly to you. Repeated returned checks will result in acceptance of cash only at the time of all future visits.
7. **Missed appointments**. Our policy is to charge for missed appointments not canceled within 24 hours prior to the scheduled appointment. The charges will be your responsibility. Multiple missed appointments may result in your being discharged from the practice. Please help us to serve you better by keeping your regularly scheduled appointment.

It is our privilege to provide quality health care to our patients. Please let us know if you have any questions or concerns about our financial policy.

I have read and understand the financial policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

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Relationship to patient