GastroCare of El Paso

FINANCIAL POLICIES

PAYMENT AT THE TIME OF SERVICE

As a courtesy, we will bill your insurance for all services we provide; however, we ask that you pay any portion of your financial liability for care, including/not limited to co-pays, deductibles or co-insurance, prior to the service.

INSURANCE INFORMATION

Your health insurance is a contract between you and your insurer. Any charges not paid by your insurer for any reason are your responsibility. It is your responsibility to understand your insurance ben fits, including plan limitations, the difference between screening or preventative care benefits versus diagnostic procedure benefits and need for referrals or pre-certifications. We will make every effort to verify your benefits, identify your financial liabilities and obtain any necessary pre-certifications prior to your appointment on your behalf; however, this is not a guarantee of payment. Different service locations may require differing out of pocket expenses .

OPEN BALANCES

It is our policy to collect payment in full at the time of service. If you need to make special payment arrangements, it is your responsibility to initiate this effort with our offices. As a last resort, patients who fail to adhere to our financial policies may be sent to collections, occur additional costs and be terminated from our practice. Identified balances on account may be refunded only during the final week of the month.

PAYMENT OPTIONS

Our statements are sent out monthly. For your convenience, we accept payment in the form of cash, check or major credit cards. You may make secure payments through our patient portal which may be found on our website. You may have outstanding balances for more than one location within the practice. We reserve the right to collect on balances for any division or affiliate and in the order they were incurred, if needed.

MISCELLANEOUS FEES

We will charge $30 for returned checks for any reason. Failure to remedy the returned check may result in legal action. Missed appointments or appointments cancelled with less than 24 hours notice for office visits and 48 hours for procedures will result in a fee of $25 (office) and $100 (procedure). Our fee for completing forms is $25.

PATIENT’S REASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand and accept the financial policies of GastroCare Of El Paso, and its subsidiary locations. I authorize payment of any insurance coverage and benefits to GastroCare Of El Paso and authorize them to release any medical information necessary to process claims. I give GastroCare Of El Paso permission to apply payments received to balances among its locations, including application to oldest balances first. I understand that I am ultimately financially responsible for the services I receive from GastroCare Of El Paso and its subsidiaries. Should I neglect to meet my financial responsibility, I understand that I may be charged additional fees incurred in the collection process, including from third party collection agencies.

Patient Signature*:

*Patient Authorized Representative (or legal guardian if minor)		Printed Name
Patient Name (if different than above)	Date of Birth	Date