Center for Colon and Digestive Diseases

7150 Smoke Ranch Rd., Ste. 110 • Las Vegas, NV 89128

P: (702) 948-9480 • F: (702) 948-9488

OFFICE FINANCIAL POLICY

PATIENT NAME (Please Print): ____ DATE_______________

The following is our office financial policy. Please read and sign prior to treatment.

Primary Insurance: As a convenience to our patients, we will bill most primary insurance carriers for you. If an insurance company has not paid within 60 days of billing, payment is due in full from you. All co pays, deductibles and patient responsibilities are due at the time services are rendered

Secondary Insurance: If you provide a valid secondary insurance information in a timely fashion, we will submit secondary insurance claims on your behalf including any secondary insurance that is part of a government-managed program (i.e. Medicare, Medicaid, TRICARE and CHAMPVA) and no fees will be due at the time of service.

Insurance Eligibility: It is your responsibility to understand your insurance agreement, eligibility, effective date(s) and what benefits you are entitled to. You are responsible for verifying the physician's status with your insurance company (such as *in-plan, in-network, preferred, out of network,* etc.). Preventative health checks, labs and injections may or may not be covered under your health insurance policy. If you are unsure of your plan benefits, call your insurance prior seeing the physician because ultimately you are responsible for all fees for service.

Referrals and Authorization: If your insurance company requires a referral for any services rendered, it is your responsibility to obtain any referral forms, referral numbers and/or authorization numbers prior to your visit. Please note that some providers may offer to assist you in this process, but this does not relieve you of the financial responsibility should any subsequent claims be denied by your insurance for lack of prior authorization. If you did not obtain a referral or any other required authorization from your insurance company, you may be asked to reschedule your appointment, or you will be responsible to pay your visit in full.

Cash Pay: Unless prior arrangements are made, full payment is due at the time of service for cash patients. If you wish to see the physician where no benefits will be paid by your insurance, you may do so as a cash pay patient. Ask our staff for a schedule of fees.

Missed Appointments: In fairness to other patients and the physician, we require at least 24 hours notice to cancel appointments. You may be charge up to $50 for missed appointments and dismissed from the clinic after three consecutive no-shows.

Types of Payment: We accept cash, checks, debit cards and most credit cards. Personal checks returned from the bank are subject to a $35.00 return check fee in addition to the fee for service.

Past Due Accounts: Upon receipt of an Explanation of Benefits (EOB) from your primary insurance, and those with secondary insurance (if on file), we will bill you for any remaining balance as indicated by your insurance. You are responsible for paying the amount on the bill in full within 30 days, unless you have contacted our office to make other payment arrangements. Accounts will be considered delinquent if left unpaid by the due date on the statement. All such delinquent accounts may be assigned to a collection agency unless prior arrangements have been made by you or your insurance company. In the event your account is assigned to a collections agency, you will be responsible for all reasonable collection and/or court costs up to 50% of the outstanding balance at the time the account is considered delinquent. If the collection agency cannot resolve an outstanding balance, the account may be turned over to an attorney for legal action.

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: **Center for Colon & Digestive Diseases, Tousif M. Pasha, MD, MPH**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party: **Date:**

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party: **Date:**