DIGESTIVE HEALTH SPECIALISTS ARIZONA, PC
DIGESTIVE HEALTH SPECIALISTS ENDOSCOPY CENTER - ARIZONA, LLC

FINANCIAL PAYMENT POLICY AND ASSIGNMENT OF BENEFITS

Thank you for choosing us as your health care provider. We are committed to your successful diagnosis and treatment. The provision of care rendered to you will result in a bill for our services. The following is a statement of our Financial Payment Policy, which we request you read and sign prior to your treatment. All patients must complete our Information & Insurance Form, provide a current insurance card and a valid photo ID issued by a local, state or federal agency before seeing the doctor.

REGARDING INSURANCE

If we are the participating provider, all co-payments and deductibles are due at the time of service.

As a courtesy we will bill your insurance carrier for you. Your insurance policy is a contract agreement between you and your insurance company. We are not a party to that contract. If you do not inform us of any specific requirements or guidelines in your contract and your physician subsequently orders services that are not covered; we, or the selected facility will bill you directly for those charges. Your insurance company determines the amount you are responsible to pay based on your plan policy with them. These amounts will be shown on the Explanation of Benefits you will receive from your insurance company.

If your insurance has not paid your account within 45 days, the account automatically becomes your responsibility and will become due immediately. Please be aware that some of the services provided may be non-covered services or not considered reasonable and necessary under your policy, but deemed to be in your best interest by your physician.

PRIVATE PATIENTS

Private Pay patients are entitled to a discounted cash price when paid in full payment at the time of service.

A minor's parent(s) or guardian(s) are responsible for full payment. For unaccompanied minors, non-emergency treatments will be denied unless a valid medical power-of-attorney and an approved method of payment accompany the patient at the time of service.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS WE ARE BILLING YOUR INSURANCE FOR YOU. WE ACCEPT CASH, CHECK OR CREDIT CARD, WE ALSO OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.
IF YOUR ACCOUNT IS SENT TO COLLECTIONS FOR LACK OF PAYMENT, YOU WILL BE TERMINATED FROM THE PRACTICE.

Please remember that when you receive our statements, you have already received quality health care from our physicians. Prompt payment upon receiving your statement is greatly appreciated. Delinquent accounts will be assessed a finance charge of 1.5% per month or a minimum of $.50.

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

I have received the Financial Payment Policy.

X ____ Date: ____________________

(Signature of Patient or Responsible Party)

ASSIGNMENT OF BENEFITS

I, the undersigned authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or any dependents. I further expressly acknowledge that my signature on this document authorizes the provider of medical services to submit claim for benefit for services rendered to my insurance company, Medicare, Medicaid or other third party insurance, without obtaining my signature on each and every claim to be submitted for myself and/or dependents. I hereby authorize payment of all insurance, Medicare and/or Medicaid benefits otherwise payable to me to be paid directly to provider. This authorization shall remain in effect until revoked by me in writing.

X ____ Date: ____________________

(Signature of Patient or Responsible Party)