SOUTHWEST GASTROENTEROLOGY ASSOCIATES, P.C.

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Patient Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. **INSURANCE:** The patient must present an insurance card or update any changes to the insurance plan. Please remember that insurance is a contract between the patient and the insurance company and is ultimately the patient's responsibility to provide the insurance information. If you do not have insurance, payment is collected at the time of service.

2. **CO-PAYMENTS**: Co-payment is collected at the time of service. We accept cash, check or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company.

3. **NO SHOW**: Any patient who fails to keep an appointment will be charged a $30.00 fee for office visits and $100.00 for scheduled procedure appointments. The fee must be paid prior to rescheduling any appointments.

4. **OFFICE CANCELLATIONS**: Cancellations must be made 24 hours prior to your scheduled appointment. Any cancellation made with less than 24 hours notice will result in a non-refundable charge of $30.00. For Monday appointments, cancellations must be made by noon on the preceding Friday. This fee will have to be paid prior to rescheduling the appointment.

5. **PROCEDURE CANCELLATIONS**: Cancellations for any procedures must be made 72 hours prior to the scheduled procedure appointment. Any cancellation made with less than 72 hours notice will result in a non-refundable charge of $100. For Monday appointments, cancellations must be made by noon on the preceding Friday. This fee will have to be paid prior to rescheduling the appointment.

6. **COLLECTIONS**: We use Transworld collections agency. In the event an account is placed in collection status, the account would need to be paid in full prior to scheduling any appointment.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined.

______________________________	______________________
Patient Name	DOB
______________________________	______________________
Patient Signature	Date