Digestive Disorders Associates

Financial & Office Policy and Procedures

Thank you for choosing Digestive Disorders Associates (DDA) as your Gastroenterology specialty healthcare provider. We are committed to providing you and your family with the best available medical care. To keep you informed of our current office and financial policies, we require you to read and sign this agreement. We will place a signed copy in your chart, and you may keep a copy for future reference.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, and American Express. As a courtesy to you, we will bill your insurance carrier, although you are ultimately responsible for the entire bill. We cannot bill your insurance company unless you give us your correct insurance information.

(PLEASE INITIAL THE FOLLOWING)

_____1. Your medical insurance is a contract between you and your insurance company. We are not a party to that contract, and your bill is ultimately your responsibility whether your insurance company pays or not. If your insurance carrier does not remit payment in full within 60 days, the balance will be due in full by you. If payment is made directly to you for services billed by our center, you recognize an obligation to promptly remit payment to Digestive Disorders Associates. It is your responsibility to understand your insurance policy and to know if we are participating providers with your specific plan. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, and secondary insurance charges. As your medical provider, we will only supply facility information to facilitate claim processing. **Patients must present appropriate insurance information at the time of service or the visit will be rescheduled and a cancellation fee of $50 may be charged.**

_____2. **Referrals**: Patients must present a valid referral (if required) at the time of service or the visit must be paid in full or rescheduled where a cancellation fee of $50 may be charged. We do NOT contact primary care physicians for referrals. Please make sure your referral is dated, the referring physician or facility name is correct, the place of service is marked as office, and that the referral has not expired. If you are unsure of the expiration date, PLEASE verify with your primary care physician and have them mark this. (It is the PATIENT'S RESPONSIBILITY to obtain a copy of the referral for their visit.)

_____3. **Cancellation**s: Our office requires a 24-hour notice for cancellation. If an appointment is not cancelled within the 24 hour notice, the patient is charged a cancellation/no-show fee of $50.00. Failure to cancel an appointment for a procedure with the MDTEC facility within 48-hours will result in a fee in the amount of $200.00. If you believe you were charged this no-show fee in error, we allow 30 days to dispute this charge. This amount will be due prior to the patient's next visit.

_____4. Returned payments, and collection fees incurred by use of an outside collection agency are subject to the following fees added to the balance due: Returned payments: $35 per transaction. Collection Agency Fee: 40% of total balance transferred to collections and any additional attorney fees and costs that apply to collection

_____5. Medical records request require 5 to 10 business days to process and required a signed medical records release. There is a fee for this processing mandated by Maryland State Law. This fee is $22.00 plus an additional $0.73 per page for lawyer or administrative transfers. Pre- Payment is required.

_____6. **Credit Card on File**. Patients have the option of keeping credit card information on file. If there are any additional charges accessed after the insurance claim has been adjudicated, including the physician, facility, anesthesia, and pathology (lab) fees, we will use this credit card for those charges. Initials only represent that patient is aware of the option to have a credit card on file.

_____7. **Co-Payments**: Co-payments **must** be paid at the time of service. This is required in the terms of your contract with your insurance company. Any amounts that are applied to the patient's deductible are due and payable prior to the patient's next visit or within 30 days after we receive notification from your insurance company, whichever comes first. *Self-pay patients are required to pay their visits in full at the time of service.*

_____8. **Prescriptions**: Prescription refills and prior authorizations require 72 hour notice to be filled and completed. Detailed information must be left in order for this process to be completed and it is preferred that patients have their pharmacies fax over refill request on their behalf.

_____9. I consent to DDA's use and disclosure of my protected health information for treatment, payment, and health care operations. I understand that I have the right to revoke this consent in writing, except where DDA has already made disclosure in trust, based on prior consent.

_____10. **Consent for Treatment**: By signing this consent I am authorizing my provider, known as Digestive Disorders Associates (DDA) to perform and/or order another person to perform all exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition.

I UNDERSTAND THE ABOVE INFORMATION AND MY SIGNATURE BELOW ATTESTS TO MY CONSENT:

Patient's Signature:_____**Date:**_____

Patient's Printed Name: _____