Arlington Gastroenterology Services
Arlington | Southlake
Office: 817-417-4027 • www.agstexas.com • Fax: 817-417-4043

Please Initial Each Line

BILLING POLICY

As a ***COURTESY***, Arlington Gastroenterology Services (AGS) will verify insurance benefits and submit your claims for all services to your insurance company. Please remember that your individual health insurance policy is a contract between you (the patient) and your insurance company and that it is the patient's responsibility to know your insurance benefits. Be aware that some of our services ***MAY NOT*** be covered by your insurance policy and by presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status. If any provided service(s) are not covered or a deductible and/or coinsurance is due by you (patient) per your insurance company, on the day of your office visit. If you are scheduled for a surgical procedure, if a deposit is due by you (patient) it will be collected the day the procedure is scheduled or no later than ***5 BUSINESS DAYS PRIOR TO YOUR PROCEDURE.*** Please be aware that if your deposit isn't paid prior to procedure, it will be cancelled. Should any service(s) provided by Dr. Kamran are not covered by your insurance carrier, AGS will not alter your claim, diagnosis code or report a different service than what was performed in order to have your insurance cover those charge(s).

_____I understand that I am responsible for any balance on my account and it is my responsibility to obtain any and prior authorization prior to receiving treatment. Please note that prior authorization is not a guarantee of payment by the insurance carrier and I am ultimately responsible for any claims not paid by my insurance carrier.

_____I understand that it is my responsibility to ensure that AGS has my current (billing and insurance) information. I will also inform office of any changes.

_____I understand that Dr. Kamran has a contractual agreement with my health plan to collect any and all monies at the time of service. We are required to report any non-payment to your insurance plan.

_____I understand that there is a ***$35 return check fee for a NSF check*** returned unpaid from your financial institution. Payment for a return check will be due by cash, money order or a bank check. Failure to respond to return check will be turned over to the District Attorney's office for collection.

_____I understand that there is a ***$50 fee for AGS to complete any FMLA forms***. For ***Specialty letters***, there is a ***$25 fee and for Medical Records***, there is a $25 for the first 20 pages with $0.55 for each additional page. Fee is payable prior to the completion of the forms.

_____ I understand that my balance over ***90-days*** aging will be sent to a Collection Agency and I will be responsible for all collection fees, interest or legal expenses associated with any collection efforts.

Arlington
Gastroenterology Services
Arlington | Southlake

PROCEDURES

_____If your physician has sent you to our office for a ***Screening Colonoscopy***, please note that if during the course of the procedure, if the doctor finds a medical condition that requires treatment, your diagnosis will change. This means that the ***Screening Colonoscopy*** now becomes a ***Medical Diagnosis*** and will be billed as such.

_____I understand that if I am scheduled for an outpatient procedure, that the deposit for my procedure is an ***estimate*** of what I owe and NOT A GUARENTEE of my full financial obligation to AGS (Dr. Hamid Kamran). If a refund is due to you (the patient), please call our office at (817) 417-4027 to obtain our refund process.

_____I understand I must provide ***72-hours (3 BUSINESS DAY)*** notification to ***Cancel or Reschedule*** my procedure. Failure to do so will result in a $100 late cancellation fee.

Note

In an effort to keep our patients informed, please be aware that you may receive a separate bill from the following facilities:

- Surgical Facility
- Anesthesia
- Pathology Lab

Phone calls about your health information will be made to the phone numbers you list on this patient information sheet. If you DO NOT wish to have these calls made to the listed numbers, please indicate that here.

□ I DO NOT □ PLEASE CALL (_____) - _____ INSTEAD.

I _____ agree to the terms and conditions noted above.
Print Patient's Name

_____ _____
Patient/ Guardian Signature Date

_____ _____
Employee Witness Date