

## Financial Policy

Thank you for choosing Hal N Buch, MD, PC, for your gastroenterology needs. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy, which we ask you to read, sign, and return to us prior to your treatment.

- All patients must provide accurate and complete personal and insurance information prior to being seen by the doctor. Insurance referrals must be received prior to, or at the time of, your office visit.
- All applicable co-pays, personal balances, both current and prior are due at the time of service.
- We accept payment in the form of cash, check, money order and credit cards.

**Regarding Insurance:** We are participating providers for many insurance plans. We require that YOU verify our participation with your specific policy carrier. Please be aware that some and perhaps all of the services provided may not be covered services or may not be considered medically necessary by your insurance policy. It is YOUR responsibility to understand and comply with any predetermination of benefits and referral requirements of your plan. We require that the guarantor (the person who is financially responsible) is personally liable for all balances not covered by insurance. For information regarding charges (and/or pathology, laboratory, anesthesia) relating to any procedure done by Dr. Buch, please contact your medical insurance provider DIRECTLY!! The toll-free \*800\* number is on the back of your insurance card.

For billing questions regarding **procedures in our office suite**, please call: A2Z Diagnostics at 1-732-542-3200, Singular Anesthesia at 1-732-582-2533, or our doctor's bill at (845) 331-8146.

**Prescription refills:** 48 hour notice for prescription refills is requested. **Note:** Prior Authorizations for medications may take up to 10 days.

**Missed appointments:** Unless office appointments are cancelled at least 24 hours in advance, we will charge **\$25.00 for late-cancellation, \$50.00 for missed appointment, and \$200.00 for missed procedure**. Please help us serve you better by keeping appointments. These charges are NOT covered by insurance and are your responsibility.

**Account Balances:** Payment is expected at the time of your office visit. If payment is not made at the time of your office visit, a \$10.00 service charge will be applied to your account. Additionally, a \$10.00 service charge will be applied to balances remaining over 30 days. These charges are not covered by insurance and, therefore, are your responsibility.

**Past Due Accounts:** Overdue accounts will be referred to a collection agency. Legal fees incurred will be added to your account.

**Returned Checks:** For checks returned to us as **UNPAID** by your bank, we will charge a \$30.00 fee.

I have read, understand, and agree to the above **Financial Policy**.

Print Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient/Responsible Party Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_