Digestive Disorders Associates MDTEC "Rest Assured" with MD ANESTHESIA PROVIDERS

FINANCIAL POLICY

Thank you for choosing Maryland Diagnostic & Therapeutic Endo Center (MDTEC), Digestive Disorders (DDA), and Maryland Anesthesia Providers (MAP) as your Gastroenterology specialty healthcare providers. 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 will be glad to bill a maximum of two (2) insurance companies. We cannot bill your insurance company unless you give us your correct insurance information and driver's license.

(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. 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.

_____2. All co-payments, insurance deductibles and fees for services not covered by your insurance policy are due at the time service is rendered. The co-pay cannot be waived, as it is a requirement placed on you by your insurance company.

_____3. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment in full within 60 days, the balance will be due in full by you. Any balance unpaid after 60 days from the date of services rendered will be subject to interest at the annual percentage rate of 18%. If payment is made directly to you for services billed by our center, you recognize an obligation to promptly remit payment to MDTEC, DDA, and MAP.

_____4. If you are unable to keep your appointment, please notify our office at least 48 hours before your scheduled appointment. Missed appointments are subject to the following fee:

- Missed appointment: $200 for a procedure

_____5. Returned payments, and collection fees incurred by use of an outside collection agency are subject to the following fees:

- 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 collections.

_____6. Medical records request require 5 to 10 business days to process. 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 physician transfer. For patient personal use there is a fee of $.073 per page ONLY. Pre-Payment is required and patient pickup is recommended.

_____**7**. Credit Card on File. Patients have the option of keeping a credit card on file. If there are any additional charges the patient is responsible for once the insurance claim has been adjudicated, including the physician, facility, anesthesia and pathology (lab) fees, we will use this credit card for those charges. It can also be used for any upfront deductible charges.

_____8. It is your responsibility to know if your insurance company requires you to have a referral and to bring the referral to your appointment. If you do not have your referral you will be required to re-schedule, or pay in full for your visit.

_____9. Self-pay patients are required to pay their visits in full at the time of service.

_____10. You may receive up to four (4) separate bills for each of the following services, as applicable:

- Digestive Disorders Associates
- Maryland Diagnostic & Therapeutic Endo Center
- Maryland Anesthesia Providers
- Pathology lab

_____11. I acknowledge that I have received the following prior to my procedure:

- MDTEC Privacy Practice
- Physician Ownership Interest
- Patient Bill of Rights
- Description of Maryland State Law Advance Directive Policy

_____12. I consent to MDTEC's, DDA's, and MAP'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 MDTEC, DDA, and MAP have already made disclosure in trust, based on prior consent.

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

Printed Name of Patient: ______________________________Date:______________

Patient Signature: ______________________________Date:______________

OR

______________________________	______________________________	____________
Patient's Representative (Please Print)	**Representative's Signature**	**Date**

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