Arlington Gastroenterology Services
Hamid Kamran, MD, PA

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BILLING POLICY

Please Initial Each Line

_____ As a courtesy, we will submit your claims for all services to your insurance company. Please remember your individual health insurance policy is a contract between you and your insurance company and we are not a party to your contract with them. Be aware that some of our services may not be covered by your insurance policy. By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed in order that your insurance will cover the charge. You will be responsible for the balance.

_____ I understand that it is my responsibility to obtain any prior authorizations prior to receiving treatment. 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 plan.

_____ I understand that it is my responsibility ensure that Dr. Kamran's office has current and accurate billing information and to inform this of any changes in this information.

_____ I understand that it is my responsibility to know my insurance benefits and that both the physician and I have contractual agreements with my health plan to collect any monies due at the time of service. We are required to report any non-payment to your insurance plan.

_____ I understand that there is a $30.00 returned check fee for any check which is returned unpaid from your financial institution. Payments for returned checks will be due by cash, money order or bank check. Failure to respond to returned check will be turned over to the district attorney for collection.

_____ I understand that there is a $20.00 fee to complete any disability paperwork associated with my care/treatment. This includes FMLA forms. Fee is payable prior to the completion of forms.

_____ Any balance over 90-days aged can/will be sent for collection and I will be responsible for any collection fees, interest or legal expenses associated with any collection efforts.

_____ **Screening colonoscopy – if your physician has sent you to our office for a screening colonoscopy, please note that if during the course of the procedure, 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.

Phone calls about your appointments, test results, or other health care information will be made to the phone numbers you have listed on the 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.**

*** Be fully aware that a cell phone is not a secure and private line.**

Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voice mail?

❒ **YES** ❒ **NO**

PATIENT NAME *(Please Print)* _____ DATE _____

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

EMPLOYEE WITNESS _____ DATE _____

For your security, do NOT send this form to the doctor's office via email.

RESET PRINT