Carlisle Digestive Disease Associates, Ltd.
Carlisle Endoscopy Center, Ltd.

Patient Financial Policy

Thank you for choosing us as your health care provider. We are committed to providing you with quality healthcare. Because some of our patients have had questions regarding patient and insurance financial responsibility for our services rendered, we have developed this Patient Financial Policy. Please read and sign. We are here to help you and will be happy to answer any questions you may have.

1. **Insurance**. We participate with most major insurance plans, including Medicare. If you are not insured by a plan with which we participate, payment in full is expected at each visit. If you are insured by a plan in which we participate, but do not have an up-to-date insurance card, payment in full is required at each visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage provisions.

2. **Proof of Insurance**. All patients much complete our patient registration form before seeing the doctor. We will need a copy of your driver's license and current valid health insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

3. **Co-payments and Deductibles**. All co-payments and deductibles shall be paid at the time of service. This arrangement is part of your/our contract with your insurance company. It is our policy to collect a co-payment at every visit. Some insurance companies may exempt certain types of visits from needing a co-payment. It is impossible for us to know which company exempts which type of visit until we receive the insurers' explanation of benefits. If we determine that you have made an overpayment, we will promptly send you a refund for the overpayment.

4. **Claims Submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that any balance is your responsibility. If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum benefits. Your insurance benefit is a contract between you and your insurance company.

5. **Non-covered Services**. Please be aware that some, and perhaps all, of the services you receive may not be covered for whatever reason by your insurance company. Our offices follow nationally accepted standards for coding and submitting claims to insurance companies. These standards, Current Procedural Terminology, are recognized and accepted by all Federal (Medicare/Medicaid) and commercial insurers. Occasionally insurance companies misinterpret these guidelines and improperly deny payment for a service. If you believe that such a situation has occurred, we will be happy to discuss this with you.

6. **Non-payment**. If your account is over 60 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise discussed. Please be aware that if a balance remains unpaid, we may need to refer your account to a collection agency, and you and your immediate family members may be discharged from Carlisle Digestive Disease Associates, Ltd. and/or Carlisle Endoscopy Center, Ltd. Should this occur, you will be notified by certified mail that you will have 30 days to find alternative medical care. During that 30 days period, our providers will only be able to treat you for ongoing and emergency care.

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7. **Non-sufficient funds (NSF)**. Please be aware that a fee may be charged for returned checks due to non-sufficient funds.

8. **Self-pay Patients**. Please ask to speak with one of our billing specialists regarding fee and payment arrangements.

Patient Statement:

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information. I will notify you of any changes in my health insurance coverage.

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Signature of Patient or Legal Guardian Date

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Printed Name