CHICAGO GASTRO FINANCIAL POLICY

If you are covered by an insurance plan, and can provide a valid insurance card, we will bill your insurance company. Your insurance is a contract between you, your employer, and your insurance carrier. It is your responsibility to contact your insurance carrier to make sure that the seeking medical provider is contracted with your plan/network.

All patients are responsible for all charges for services received. lf the patient responsibility portion of your charges, including charges applied to your deductible and/or coinsurance are not paid in full **within 60 days** following the receipt of your billing statement, we will charge the credit card listed below for the unpaid balance**.** Payment plans are available for large account balances and can be customized to fit your needs; please contact the billing office directly for more information. All account balances not paid within 60 days will be forwarded to a Collections Agency and a 30% premium will be placed on all collections accounts.

Circle One: M/C VISA DISCOVER

Credit Card Number: _____ Expiration Date: _____

Name of card holder: _____ Security Code: _____

Cardholder billing address: _____

Cardholder phone number: _____

If you are *not* covered by one of our accepted insurance plans, you must **pay in full at the time of your service.** Many insurance plans do provide reimbursement for "out-of-network" care. Please contact your insurance company directly as to how to submit a claim.

<u>Cancelation Policy</u>

For office visits cancelled less than 24 business hours in advance or failure to keep an office appointment, patients will incur a $50.00 charge. For procedures cancelled less than 72 business hours or failure to keep a procedure appointment, patients will incur a $150.00 fee. We will charge that fee to the above credit card.

You herby acknowledge receipt of the medical services, authorize us to bill the above credit card for such services, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in your agreement with the credit card issuer.

I have read and understand this financial policy:

Patient Signature: _____ Date: _____