PATIENT FINANCIAL POLICY

It is the responsibility of the patient to keep all insurance and demographic information up to date. Co-payments are expected at the time of the visit as well as any deductibles, co-insurance payments, or payment for any non-covered services If referral is required for your visit, it is the sole responsibility of each patient to arrive with that required referral. If you do not have the required referral at the time of your appointment, payment will be due at the time of service.
A fee of $30.00 will be assessed for returned checks.

I hereby authorize Loudoun Gastroenterology to apply for benefits for services rendered. I certify that the information that I have provided regarding insurance coverage is correct. I further authorize the release of any necessary information including medical information, for any related claim to my insurance carrier to determine benefits payable. I request that payment of authorized benefits be made payable to Loudoun Gastroenterology.

I understand that I am financially responsible for the total charges for services rendered which may include non-covered services. I agree that all amounts are due upon request and are payable to Loudoun Gastroenterology. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of Loudoun Gastroenterology.

I have read the above Patient Financial Policy and have provided true and correct insurance and demographic information. I will promptly notify you of any changes to my health insurance carrier, including new ID #'s with my current carrier.

Scheduling of your procedure requires a coordinated effort of multiple departments; beginning with your doctor and including the Hospital/ Surgery Center. Evaluation at the hospital/ Surgery Center by administrative, nursing, and anesthesia staff is also a time consuming and expensive period. Also, authorization by your insurance carrier must be obtained for your operation.

Cancellation of procedure is sometimes unavoidable due to medical problems or significant conflicts which cannot be avoided. These cancellations, however, can result in unused operative time, and other patients who could have benefited from that operation time cannot do so.

Therefore, a minimum of 72 hours (3 business days) notification is required for any procedure cancellation. This allows the physician and his staff to make changes to the schedule. If you must cancel your surgery, please call the office at 703-858-3060, ex. 4.

Failure to notify us of the cancellation in the required time will result in a charge of $300.00. This charge will be posted to your account.

*** Exceptions to this policy will be made only for emergencies and conflicts beyond your control. I have read this policy and understand that cancellation of my surgery may result in a fee of $300.00**

Patient Name_____ Signature_____ Date_____