South Oakland
Gastroenterology Associates
Board Certified in Gastroenterology and Internal Medicine

Michael Biederman, D.O., M.A.C.O.I, F.A.C.C.
Steven Klein, D.O., F.A.C.O.I.
Mariquit D. Sendelbach, D.O.
Katie Sumnicht, D.O.
William Raminick, D.O., F.A.C.O.I.

FINANCIAL POLICY

Effective 8/7/13

Thank you for choosing a SOGA doctor as your Gastroenterologist!

Billing is not always a comfortable topic, but we do want to make you aware of our current office financial policies. Please read and sign the policy before any [further] treatment.

Since you are the person seeking care, please understand that YOU (or your guardian) are responsible for the payment(s) of any bills relating to your visit(s.) To help you, we will bill your insurance carrier(s) for you, after you have given us a copy of your current insurance information.

FINANCIAL TERMS:

Payments types accepted: Cash, Check, VISA, MasterCard, AMEX, and Discover
Deductible: The annual dollar amount **set by your insurance plan** that is deducted from insurance benefits and MUST be paid by you. The Deductible cannot be "waived" by our practice. This is a rule from your insurance carrier.
Co-Payments: The fixed dollar amount **set by your insurance plan** that MUST be paid at every visit. The Co-pay cannot be "waived" by our practice. This is a rule from your insurance carrier.
Co-insurance: The percentage **set by your insurance plan** that is deducted from insurance benefits and MUST be paid by you. The Co-insurance cannot be "waived" by our practice. This is a rule from your insurance carrier.
Self-Pay: The dollar amount to be paid by the patient, who has no insurance benefits. This is due at the time services are rendered. Payment will be determined at the time of visit. (Can be up to $160.)

It is YOUR responsibility to know your own insurance plan and coverage. Your benefit plan is between you and your insurance carrier, NOT between our physicians and your insurance carrier. If you do not know your coverage, please contact your insurance(s) prior to your appointment. **You** are responsible for any charges listed above that applies to you, as well as any charges at the time service is rendered that may not be covered by your insurance.

OVERDUE BALANCES:

Because many patients carry high balances on their accounts and never make a payment, we have revised our payment policy. For patients who faithfully pay their co-pays and/or make payments on their balances, we thank you and appreciate the opportunity to provide your medical care.

Patients who have overdue balances, a breakdown is listed below for payment.

For balances of less than $100, we will collect 100% payment
For balances of $100-$250, we will collect 50%
For balances of $250-$500, we will collect 35%
For balances of $500 and above, we will collect 25%

Patients with past due accounts will be asked to make payments in full before being seen in our office for anything other than surgical follow-ups. You may contact our business office (800-827-3797) regarding payment arrangements. If your account is sent to our collections agency, you will need to call our collections agency (888-500-9670) to pay your balance or make payment arrangements.

You will be reminded of your balance when you receive your confirmation call about your appointment. If you are unable to make a payment on your balance, you will be asked to reschedule your appointment. We apologize for any inconvenience this rescheduling may cause. If you have any questions, please contact our office.

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"NO SHOW" POLICY:

We understand that emergencies happen. However, when a patient cancels an appointment without enough notice or does not show up, this does not allow us enough time to be able to accommodate our other patients. We ask that you please call **at least 24 business hours** in advance to cancel your appointment. Patients who fail to cancel or call will be subject to the $35 "No Show" fee for an office visit and a $50 "No Show" fee for a scheduled procedure**. This fee will be charged to the patient, because it is not covered by insurance.**

RETURNED CHECKS:

A $25 fee will be added to your account for any checks that are rejected by your financial institution for any reason. This is in addition to any fees that your financial institution may charge you.

DISABILITY FORMS, INSURANCE FORMS, AND MEDICAL RECORDS:

PLEASE ALLOW 7-10 BUSINESS DAYS FOR COMPLETION OF YOUR FORMS OR COPY OF RECORDS!

Our office will complete your forms for a fee of $10, and MUST be paid by the patient BEFORE the forms will be filled out. Your insurance company will not pay this fee; it is the patient's responsibility. If you would like your forms to be mailed to you or your insurance company, payment will be due prior to mailing.

The fees associated with the medical record copying are within Michigan state statutes. We will provide you with a copy of your medical records upon request. You will need to sign a letter of release at the time of the request, or pick up. If you wish for your records to be mailed, there will be an associated fee to cover the mailing costs. You may be charged for additional copies of your medical records.

REFERRAL POLICY:

It is your responsibility to obtain an insurance referral from your Primary Care Physician's (PCP) office. As the patient, it is up to you to make sure that our office is notified of **ANY** REFERRAL needs that you have, at least 7-10 business days prior to your appointment. (IE. If you are seeing one of our doctors, or having a MRI/CT/Radiology service or surgical appointment.) Failure to call our office to tell us that you need a referral may result in cancellation/rescheduling of your appointment.

I, THE UNDERSIGNED, HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS OF THIS FINANCIAL POLICY. I ASSUME FULL FINANCIAL RESPONSIBILITY FOR PAYMENT OF ALL EXPENSES ASSOCIATED WITH MY CARE AND TREATMENT, INCLUDING ANY PORTION OF HOSPITAL OR PHYSICIAN CHARGES THAT ARE NOT COVERED BY INSURANCE (EXCEPT AS EXCLUDED BY PARTICIPATING HOSPITAL AGREEMENT,) WORKER'S COMPENSATION OR SOCIAL AGENCIES. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE WITHOUT PRIOR NOTICE.

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Print Patients Name CLEARLY D.O.B.

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