



Advanced Gastroenterology Associates
Allied Digestive Health Pathology
Atlantic Coast Gastroenterology Associates
Monmouth Gastroenterology
Red Bank Gastroenterology Associates
Shore Gastroenterology Associates
Middlesex Monmouth Gastroenterology

Patient Financial Responsibility Statement

Thank you for choosing our practice for your healthcare needs. It is our goal to provide you with the highest quality healthcare services as possible. We ask that you please read and understand your financial responsibilities prior to receiving services.

Patient Name: _____

1. I understand that I am responsible for knowing the policy provisions and rules of my insurance coverage(s) and that I am solely responsible for obtaining any necessary referrals prior to my appointment. Failure to obtain and present a valid referral may result in my being financially responsible for all services provided.
Please note: a Doctor's Prescription is NOT a valid Referral.
2. I understand that I am financially responsible for any amount not covered by my insurance including, but not limited to, co-pays, co-insurances, deductibles and non-covered services.
3. I understand that if I do not have valid medical insurance, I am financially responsible for all fees for provision of medical services and that, unless other arrangements have been made in advance, payment of these fees is expected in full at the time services are rendered.
4. I understand that failure to remit payment for any amounts deemed patient responsibility may result in my account being referred for collection activity and that I will be financially responsible for any additional fees incurred as a result.
5. I understand that any appointments missed, but not cancelled within twenty-four (24) hours, will result in my being charged a Missed Appointment Fee of \$35 per missed office visit and \$300 per missed procedure.
6. I understand that I will be charged \$35 for any check returned by my bank for any reason.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I UNDERSTAND AND AGREE TO THESE TERMS:

Signature of Patient or Guardian

Today's Date



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Assignment of Benefits

I hereby authorize any insurance carrier, including Medicare, to make payment directly to Allied Digestive Health for any services rendered to me or my covered dependents of any amounts otherwise payable to me toward the reimbursement of any medical expenses incurred at this facility. **I understand that I am financially responsible for payment of all services regardless of any payment issued by my insurance or not.** A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Patient or Guardian

Today's Date

Release of Medical Records and Information

I hereby authorizes the release of any Protected Healthcare Information (PHI) to any involved insurance company, or their authorized third parties involved in my case unless I have specifically instructed otherwise.

Signature of Patient or Guardian

Today's Date

Medicare Patients ONLY

I understand that Medicare may not cover this service. I have been given a Medicare Advanced Beneficiary Notice of Non-Covered Service (ABN) which explains my options for procedures that may not be covered by Medicare.

Signature of Patient or Guardian

Today's Date

Colonoscopy & Endoscopy Patients ONLY

I understand that Allied Digestive Health's bills for its physicians ONLY: In addition, I may be responsible for, and receive a separate bill (when applicable) from:

1. The Hospital or Endoscopy Center for any facility fees.
2. The Laboratory / Pathologist for any tissue/biopsy testing.
3. The Anesthesiologist for provision of any anesthesia.

I further understand that the final determination of whether an exam is considered "screening" or "diagnostic" cannot be made until the results are complete. I have received and understand a copy of "Colonoscopy: Screening, Surveillance or Diagnostic. I acknowledge that the physician's determination is final and will not be changed for the purpose of reconsideration / overturning of insurance decisions.

Signature of Patient or Guardian

Today's Date