Freehold Endoscopy Associates, LLC
d/b/a ENDOSCOPY CENTER OF MONMOUTH COUNTY

NOTICE OF FINANCIAL POLICIES

Welcome and thank you for choosing the Endoscopy Center of Monmouth County (ECMC) for your medical care. If you have medical insurance and/or other third party coverage, referred to as Insurance, ECMC shall assist you in obtaining the maximum allowable benefits. In order to achieve this goal, ECMC needs your assistance and understanding of our financial policy as our relationship is with you not the Insurance. Acknowledgement of this form via your signature shall be included as part of the patient's medical record.

If you have questions regarding insurance or billing, please contact our Billing Manager at 732-845-0991.

Things to bring on day of procedure

- Health Insurance cards
- Form of payment, if necessary
- Driver's License or another form of picture identification

Insurance Coverage and Payment Policy

1. As a courtesy, we bill your insurance(s):
2. You shall be responsible for:
   - Annual deductibles
   - Co-Insurance
   - Co-payment
   - Any non-covered charges, **you will be asked to sign an Advance Beneficiary Notice or Notice of Non-Coverage if the service(s) provided is known to be a non-covered service.**
3. You shall receive a statement for any remaining balance ***after your insurance company makes payment***.
4. All checks should be made out to ***Freehold Endoscopy Associates, LLC.***
5. For patients who have no insurance, pre-payment on the date of the procedure is required. When scheduled, an estimated amount shall be provided and any additional balances due shall be billed and you will be notified of any outstanding expected balances.

- We participate with most major health plans; however it is *your responsibility* to verify that we are a participating provider with your insurance. You bear final responsibility for payment of services rendered.
- If you have insurance coverage, it is important for you to be aware of your out-of-pocket costs for payments not covered by your insurance.
- We recommend that you contact your insurance company to discuss these costs prior to your procedure.
- Also, you will need to verify whether or not our physician and anesthesiologist, participate with your insurance plan.
- **Payment for any balance is expected and payable in full within 90 days from the date you receive our statement.**

Balance Due Statements

- If you have a balance due on your account, you shall receive a statement from our office.
- Statements are mailed out monthly by first class mail. We trust all mailed statements are received.
- **All balances are due and payable, in full, within 90 days from the date you receive our statement.**
- If payment in full is not received within 90 days or you have not discussed payment arrangements with our Billing Manager, any past due account may be reviewed for possible transfer to an external Collection Agency.

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Referrals and Pre-certifications

- *As a courtesy*, we will contact your insurance company to obtain pre-certification for procedures scheduled.
- Pre-certification is not a guarantee of coverage and/or payment.
- Referrals should be obtained by you from your primary care physician.
- *It is your responsibility* to contact your insurance company to determine your coverage. We provide procedure codes and diagnosis information needed when inquiring about your coverage.

Procedure Billings

You will receive invoices for the following services:

- For your gastroenterologist's **professional services (**from **your gastroenterologist's office)**
- For **anesthesiology services (from Middlesex/Monmouth Gastroenterology, or Anesthebest, LLC)**
- For the **facility services (**from **Freehold Endoscopy Associates, LLC,)**
- **The Laboratory/Pathologist for any tissue/biopsy testing**

"Screening" vs. "Diagnostic" Coverage

- In some instances, when a screening is performed and there are findings, your plan may consider the procedure as diagnostic/medical, and therefore co-pays, deductibles, co-insurance may be applicable. This is plan specific. You need to know that the final determination of whether an exam is considered "screening" or "diagnostic" cannot be made until the results are complete. I acknowledge that the physician determination is final and will not be changed for the purpose of reconsideration /overturning of insurance decisions.

Returned Check Charge

- If a check is returned from a financial institution to Freehold Endoscopy Associates for any reason, you shall be billed the amount and an additional processing fee of thirty-five dollars ($35).

Payment Plans

- Our office is happy to work with you in order to pay any balance due. Please contact our Billing Manager (732-845-0991) to work out a payment plan.

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Medicare Certification and Authorization for Medicare Beneficiaries: Patient's Certification: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request payment of the authorized benefits be made either to me or on my behalf for any services furnished me by or at ECMC including physician and ancillary services. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

Assignment of Benefits: I hereby assign the benefits due to me through the Insurance to ECMC and/or approved healthcare provider for any professional or technical services that may be furnished. I authorize and instruct the Insurance to make payments of authorized benefits directly to ECMC or to an approved healthcare provider for any professional or technical services that may be furnished. I understand that I am responsible for any services not paid by the Insurance and other not covered services by the assignment. I authorize release of all records required to act on this request. If Insurance refuses to make a payment to ECMC or an approved healthcare provider on my behalf, I give consent to ECMC or an approved healthcare provider to appeal the denial of the payment.

Collection Policy: I agree, in order for ECMC to service my account to collect any amounts owed, ECMC may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. ECMC's collection policy is to turn all unpaid accounts and balances over for collection activity ninety (90) days after the balances are transferred to patient financial responsibility if no arrangements are made. No future services shall be provided if patient's financial responsibility balances are due for other dates of service.

Financial Agreement/Guarantee of Payment: If Insurance rejects the patient's bill or pays partial payment for ECMC's services, then I shall be financially responsible for any portion of the patient's services that Insurance does not cover, and I agree to pay all uncovered charges. By signing and acknowledging this form I understand that all uncovered charges are due and payable upon receipt of my statement.

I understand and acknowledge that separate bills may be generated for each of the following services, as applicable: facility fee, physician provider, anesthesia, laboratory, and pathologist.

I understand and acknowledge that the estimated balances given to me by ECMC for services rendered may increase or decrease pending on the services rendered or Insurance changes from the date the Insurance was verified by ECMC. ECMC shall make every attempt to refund any patient's financial responsibility after the Insurance pays ECMC within ninety (90) days. If discrepancies exist between the benefits provided at Insurance verification and Insurance payment, ECMC shall make every attempt to verify the discrepancies prior to refunding the patient's financial responsibility. **CHECKS AND VISA/MASTERCARD/CARE CREDIT ARE ACCEPTED**.

I understand and acknowledge that all ECMC costs for returned payments shall be considered the patient's financial responsibility and added to the balance.

Patients with No Insurance: Self-pay patients are required to pay in full all allowable charges incurred for the rendered services at ECMC, with the exception of unpaid accounts and balances. Unpaid balances may revert to full charges. If special arrangements need to be made, a payment arrangement may be accepted for you with our Billing Office.

5/2017

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FINANCIAL POLICIES ACKNOWLEDGEMENT AND ACCEPTANCE TERMS

I, _____, am acknowledging I have reviewed a copy of the "Notice of Financial Policies" document from Freehold Endoscopy Associates, LLC, d/b/a Endoscopy Center of Monmouth County (ECMC) and I agree to the terms of the policies. A written copy shall be furnished to the patient upon request.

_____	_____
Patient or Authorized Representative Signature	Date
_____	_____
Printed Name of Patient or Authorized Representative	Authorized Representative Relationship
_____	_____
Witness Signature	Date

Driver's License verified by staff □