

**GASTROENTEROLOGY ASSOCIATES OF NORTHERN VIRGINIA, LTD.**  
*Practice Payment and Financial Policy*

**Referrals and Authorizations:**

1. I \_\_\_\_\_ understand that it is my responsibility to contact and secure from my insurance plan any referrals, pre-certifications or authorizations prior to receiving any non-emergency medical services from the Practice. If no referral is obtained, the appointment will be rescheduled.

**Financial Agreement:**

2. The Practice will file for insurance benefits and accept payments per contractual agreements with participating insurance companies. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and the insurance company. Any assistance granted by the Practice is given strictly as a courtesy.
3. I \_\_\_\_\_ also understand that I will be billed separately for “non-covered” or “incidental” services related to patient care, including, but not limited to: telephone and/or e-mail consultations, emergency prescription refills or other convenience oriented care rendered.
4. I \_\_\_\_\_ also understand that there will be a charge for medical records or any medical forms which need to be filled out by the physician.
5. I \_\_\_\_\_ also agree to pay a \$50.00 fee for missed appointments not cancelled twenty-four 24 hours prior to the scheduled appointment and a \$100.00 fee for any procedures not cancelled four (4) days prior to the scheduled procedure.
6. Should any balances arise due to insurance co-payments, co-insurance, deductibles, insurance denials, termination of coverage, non-addition of a dependant to insurance plan, non-payment at time of service and/or any other reason, I \_\_\_\_\_ agree to pay all charges within sixty (60) days of services rendered. Interest of one and one half percent (1 ½%) per month, eighteen (18%) per annum may be charged on all delinquent accounts over sixty (60) days.
7. I \_\_\_\_\_ agree that if for any reason a check is returned on my account, I will be responsible for a \$25.00 returned check fee in addition to the original fees for services.
8. If the balance is not paid within thirty (30) days or if agreed upon payment arrangements on my account is not made, the practice will retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my delinquencies

**Certification of Insurance and Billing Accuracy:**

9. I \_\_\_\_\_ certify that the information I have reported with regard to my insurance coverage is correct and that the above be honored by my insurance carriers.
10. I \_\_\_\_\_ agree to inform the Practice immediately of any change in insurance coverage and/or benefits and change of personal information.

**Office Policies:**

11. All prescription requests and pre-authorizations for medications will be handled within forty-eight (48) hours of receipt. Any requests received after 2:00 pm on Fridays will not be handled until the following week.
12. Test results will be discussed at the next appointment. If there are any results that are of concern, you will be contacted by phone.
13. In an effort to reduce call volume, please leave only one phone message. Multiple phone messages only overload the phone system and will not ensure a return call any sooner. To better serve you, we ask that when leaving a voicemail message, be sure to clearly state the patient’s name, spell the last name, give the patient’s date of birth and a phone number where you can be reached easily.
14. Any follow-up appointments should be made while checking-out. The schedule usually fills up quickly and may take up to 6-8 weeks for a return appointment,
15. In an effort to see patients on time, we request that you arrive thirty (30) minutes prior to your appointment time. Patients arriving thirty (30) minutes late will be rescheduled.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_