DIGESTIVE DISEASE & NUTRITION CENTER OF WESTCHESTER, LLP

Excellence in Gastroenterology and Nutrition for over 25 years

PATIENT AGREEMENT & FINANCIAL POLICY

Patient Name: ________________________________ Date of Birth: ________________

OFFICE POLICIES:

_______ (Initial)

APPOINTMENTS RESCHEDULING: We ask for 2 days notice to reschedule or cancel appointments. This courtesy allows us to schedule another patient in your place. If an emergency arises, please give us as much notice as possible.

ADMINISTRATIVE CHARGE Minimum notice of 48 hours is required to cancel or reschedule an appointment. This helps other patients to access care in a timely manner. In order to discourage patients from making last minute cancellations and preventing other patients' access to care, administrative fee will be charged as per the following schedule:

Notice of 48 hours or more: No fee
24 hours notice cancellation/rescheduling: $25.00
Same day cancellation/rescheduling/no show: $50.00

We ask that new patients arrive fifteen minutes early to fill out paperwork. When a patient is more than 10 minutes late, we reserve the right to shorten or reschedule the appointment, if needed, to not inconvenience other patients.

RETURNED CHECK FEE: There is a $50 returned check fee for any checks returned to us by the bank.

INSURANCE COVERAGE

_______ (Initial)

REFERRALS: It is your responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will be rescheduled, or you may be financially responsible.

INSURANCE CARD: Please bring your insurance card as you must present your insurance card at the time of your appointment. Without the presence of an insurance card, you will need to pay in full at the time of service. We will provide you with a receipt which you may submit to your insurance company yourself.

COPAYS: All copays are due at the time of service. If we have to bill you for a copay, there will be a $10.00 billing fee.

NONCOVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES: This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

OTHER: You are responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic services. Patients who are covered by private, commercial plans in which our physicians are not providers are responsible for the entire unpaid balance left after payment from your insurance, regardless of the benefits and payment policies of your carrier.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize the release of medical information to my primary care or referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

MEDICARE PATIENTS

_______ (Initial)

SIGNATURE ON FILE: I request payment of authorized Medicare benefits be made either to me or

on my behalf to the Digestive Disease & Nutrition Center of Westchester, LLP for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

PRIVACY PRACTICES

_______ (Initial)

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By My signature below I acknowledge receipt of the Notice of Privacy Practices and have read the above financial policies.

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SIGNATURE (Must be 18 or over) DATE