

**PENINSULA GI MEDICAL GROUP**  
**OUR FINANCIAL POLICY**  
**Beginning January 2007**

Thank you for choosing *Peninsula GI Medical Group* as your health care provider. We are committed to providing you the best possible medical care. Please understand that payment of your bill is important. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

\*\*All Patients must complete a Patient Information Form before seeing the doctor.

***Regarding Insurance:***

As a courtesy our office will bill your insurance for the services you will receive. We cannot bill your insurance company unless you give us proper insurance information. Please understand that your bill is ultimately your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 business days, it will then become your responsibility to pay the balance. We accept Cash, Check, Visa and Master Card.

\*\*All co-pays are due at the time of treatment.

***Usual and Customary Rates:***

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance.

***Missed Appointments:***

Due to the amount of time allotted for scheduled endoscopic procedures, we do request at least 2 working days notice for cancellation of any procedures. **It is our policy to charge a \$300.00 cancellation fee if given less than 48 hours notice. We will waive this fee if we are able to fill your procedure time; however, there is no guarantee that we will be able to do that in such a short amount of time.** If you are scheduled for an office appointment, we must receive a notice of cancellation at least 24 hours in advance. Our policy is to charge for missed appointments at the rate of a normal office visit. The charge for a late cancellation/no show procedure or appointment will be billed directly to you and not to your insurance. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy in full and I understand and agree to this policy.

\_\_\_\_\_  
Printed Name of Patient

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

\_\_\_\_\_  
Date Signed