GI OF NORMAN, LLC

Financial Policy

Your physician is honored that you have chosen him. The following is his Financial Policy. His main concern is that you receive the proper and optimal treatment needed. Therefore, if you have any questions or concerns about the payment policies, please do not hesitate to ask the billing department. All patients are asked to read and sign the Financial Policy as well as complete the Patient Information form prior to seeing their doctor.

Payment for services is due at the time services are rendered. Your doctor accepts cash, checks, MasterCard, Visa, Discover, and American Express. The office staff will be happy to file your insurance claim for you. However, please be aware that, although your physician has contracts with several insurance companies, he is not on all PPO or network plans. Please be sure to inquire as to your physician's status with your particular insurance company, as this may affect the amount you are responsible for paying.

Please note that if you are a member of an HMO or Managed Care program and/or have a primary care physician (PCP), you are responsible for contacting your PCP for a referral number prior to your visit, if applicable. If you fail to do so, your visit(s) may not be covered by your insurance, making you financially responsible.

All charges are your responsibility whether your insurance pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services along with unpaid deductibles and co-payments are due at the time services are rendered. If the insurance company does not pay your claim within a reasonable time frame, you will be required to follow up with them and/or pay the balance.

Temporary financial problems may affect timely payment of your balance. It is imperative that you communicate such problems to the billing department so that they can assist you in the management of your account.

During the course of your medical care, it may be necessary for one or more providers to assist with your medical treatment. You agree to acknowledge that any overpayment or credit balance that you may have with one of the practices within the office is hereby assigned to any of the other practices within the office to which you may have a debt or outstanding balance due. To the extent that you have no balance due to any of the practices within the office upon completion of your medical treatment, any overpayment will be refunded AFTER ALL CLAIMS HAVE BEEN RESOLVED.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor and staff to release all information necessary to secure the payment of benefits.

Print Name_____ Date of Birth_____

Patient's Signature_____ Date_____