Greater Boston Gastroenterology, P.C.
Patient Payment Policy

Thank you for choosing Greater Boston Gastroenterology, P.C. as your Digestive and Liver healthcare provider. We are committed to providing you with quality health care. For our patients to understand their responsibilities relating to payment for our services, we have established this payment policy. Please read it, ask us any questions you may have, sign in the space provided and return your signed copy to us. A copy will be provided to you upon request. **We cannot provide services without a signed copy of this policy.**

1. Insurance Coverage. We participate in most insurance plans, including Medicare. If you are insured by a health plan that does not contract with us, payment in full is due and expected at the time of each visit. If you are insured by a health plan that does contract with us, but you do not have an up-to-date insurance or plan member card, payment in full is due and expected at the time of each visit until we can verify your coverage. Providing us with all information needed to demonstrate your current and active health insurance coverage or plan, your current membership status, and generally knowing about the terms and conditions of your health insurance benefits, including any needed pre-approvals and referrals is your responsibility. Please contact your health plan or insurance company with any questions you may have regarding your coverage before making any appointments with our office or with our physicians for procedures at other facilities.

2. Co-payments and deductibles. All co-payments and deductibles are due and expected at the time of each visit. The amount of your required co-payment and/or deductibles is established under your health plan or insurance coverage and we are required by law and our contract with your health plan or insurer to collect that amount from you. We therefore will require every patient to pay their applicable co-payment, and in some cases a deductible amount, at each visit. A $25 service fee/processing fee will be charged if your copayment cannot be collected at the time of your office visit.

If you participate in a high deductible plan, special payment arrangements, such as requiring that a copy of your health savings debit/credit card or a personal credit card to remain on file, may be required. The IRS currently defines a high deductible health plan as any plan with a deductible of at least $1,350 for an individual or $2,700 for a family. Deductibles that are in excess of these amounts will generally require special arrangements.

We accept MasterCard, Visa, Discover, cash and checks.

3. Non-covered services. It is your responsibility to understand your benefit plan and know your plan's pre-authorization plan requirements for our services, including whether your plan requires you to first secure a written or electronically verified referral from your health plan before your visit. Please be aware that some – and perhaps all – of the services you receive from us may be not be covered by your plan or insurance coverage and/or may denied for coverage and payment based upon "medical necessity" considerations by Medicare or other insurers. If your plan refuses to authorize and/or denies coverage for any services which you seek from our practice and its physicians, we reserve the right to charge you at our fee schedule rates. When it is known at the time of your visit that your plan will not cover a given service, we require payment in full for any such uncovered services at the time of visit. A copy of our fee schedule is available upon request.

4. Proof of Health Plan/Insurance Coverage. All patients must provide us with complete and up-to-date information about their health plan/insurance coverage. At your first visit with us you will be asked to complete our patient information form which is required before you may be seen for any visit. We must also obtain a copy of your driver's license to verify your identity and current valid health plan or insurance membership card to provide proof of insurance. You are responsible for keeping us updated as to any changes in your health plan/insurance coverage. If you fail to provide us with the correct insurance information or if you are not insured, you may be financially responsible, and we reserve the right to charge you at our fee schedule rates and require payment in full for any such uncovered services at the time of visit. The balance of a claim must be paid in full at the end of each visit. A copy of our fee schedule is available upon request.

5. Claims submission. We will submit a claim for payment for any covered services we render to your health plan/insurer. We will reasonably assist you to help get our claims paid by your health plan/insurer. Your health plan or insurance company may need you to supply certain information directly. It is your responsibility to comply with their payment requirements and any specific requests for information.

IF YOUR HEALTH PLAN OR INSURANCE COMPANY DENIES OUR CLAIM FOR PAYMENT, PLEASE BE AWARE THAT THE BALANCE OF YOUR CHARGES IS YOUR RESPONSIBILITY AND WE WILL EXPECT PAYMENT WITHIN 30 DAYS OF YOUR DATE OF SERVICE UNLESS SPECIAL ARRANGEMENTS ARE MADE WITH OUR BILLING OFFICE.

Your health insurance benefit is a contract between you and your health plan/insurance company; we are not party to that contract.

6. Coverage changes. If you switch your health plan or insurance or there are changes to your coverage within your existing plan or policy, it is your responsibility

to notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If your account is over 30 days past due, including any failure of your plan or insurer to pay our submitted claims, you will receive a letter stating that you have another 30 days to pay your account in full or your account may be referred to a collection agency. Partial payments will not be accepted unless otherwise approved by us in advance in writing. A one and a half (1.5%) percent per month finance charge will be assessed for all bills and account balances that are not received within 30 days of the first past due notice. We reserve the right to discharge any patient from the practice for non-payment. If you are discharged from the practice for non-payment, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Late/Missed appointments. If you are late for a previously scheduled appointment, we will do our best to accommodate you, but we may need to reschedule your appointment time. Our policy is to charge $50.00 for missed office appointments not cancelled at least 24 hours before your planned visit. Our policy is to charge $150.00 for missed endoscopic procedures not cancelled at least 48 hours before your planned visit. These charges will be your responsibility and will be billed directly to you only. Please help us to serve you better by keeping your regularly scheduled appointment.

9. **Additional fees.**

We charge $25 and any additional bank fees incurred by the practice for checks returned due to insufficient funds.

We charge fees for any request you authorize to copy and deliver your medical records to other parties as follows:

- A base fee of $15 per request
- Fifty cents ($0.50) per page for the first 100 pages, and $0.25 per page for every page after 100
- Actual cost for copying x-rays and other records not reproducible by photocopying, plus a clerical fee of $20 per hour
- Actual cost of postage, shipping, or delivery if you request the records to be mailed

We charge $25 to complete any special forms such as disability forms, forms required by your employer before returning to work, or for family or medically

necessary leave. This fee is due and must be paid before the forms are delivered by us or at time they are picked up by you.

If it has been more than 7 days since your last office visit, we reserve the right to charge for phone conversations and/or after-hours/weekend phone calls **that you initiate** and that require medical advice, new prescriptions, referrals or treatments. **These interactions are not covered by your health plan or insurer**. Charges run in 10-minute intervals: 0-10 minutes ($30), 11-20 minutes ($60), and 21-30 minutes ($90). These charges will be waived if an in-person office visit or procedure is necessary for the same problem within 24 hours or at the soonest available appointment time after the phone conversation.

Secure video consultation (sometimes called telehealth or telemedicine services) are live interactive audio and video transmissions from one site to another. **Some plans will cover these services using a special code**. These visits will be billed at the self-pay rates on our fee schedule if they are not covered under your health plan or insurer. Please contact your health plan or insurance company with any questions you may have regarding your coverage for telemedicine services before making an appointment request.

Unless otherwise covered by your health plan/insurer, we charge $75.00 per hour for our physicians to participate in medical team conferences, family meetings, or discussion and/or coordination of your care with new physicians if they do not occur at the time of your regularly scheduled visit.

We will submit the required paperwork and forms in order to help manage the pharmacy benefits, procedures, and imaging test approvals for your insurance plans. If coverage of your properly submitted paperwork and forms is denied and you ask us to submit an appeal of the denial and that appeal requires us to speak directly with the plan or its medical director, there is a $25 per hour fee for our clerical staff work and $75 per hour fee for our physicians.

Our practice is committed to providing the best quality treatment to our patients.in order to do so we ask that you understand and cooperate in carrying out these policies so we can assure payment for our services.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**