Indianapolis Gastroenterology & Hepatology
The Endoscopy Center at St. Francis

Patient Name: _____
Date of Birth : _____
Email Address: _____

FINANCIAL POLICY

Thank you for choosing **Indianapolis Gastroenterology & Hepatology** as your health care provider. We are committed to providing you the best possible medical care. We want to keep you informed of our current office and financial policies.

Insurance: As a courtesy, our office will bill your insurance for the services you receive; therefore, we must have your correct insurance and driver's license. Please understand that your insurance is a contract between you and your insurance company. We are not a party to that contract and your bill is ultimately your responsibility whether your insurance company pays or not. We can often help with providing information to help get your claim paid, but 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.

Co-Payments, deductibles and fees: All co-payments, insurance, deductibles and fees for services not covered by your insurance policy are due at the time service is rendered. The co-payment cannot be waived, as it is a requirement placed on you by your insurance company.

Payment: We accept cash, money orders, and personal checks, Visa, MasterCard and Discover. On-line payment is available.

Credit Card on File: It is the policy of this office to request that credit card information be provided at the time of scheduling. The signature below indicates my consent for IGH to process authorized transactions as outlined in the IGH Credit Card on File program. Please refer to our Credit Card on File Policy information provided separately.

Missed appointments: If you are unable to keep your scheduled appointment, please call our office at least 24 hours in advance. This will allow us to provide that time to schedule another patient. It is our policy to charge for office appointments that are **not cancelled at least 24 hours in advance**. This fee cannot be billed to insurance and is the responsibility of the patient. ***An established patient incurring two missed appointments must pay a deposit to hold their next appointment slot. Upon appointment arrival, the deposit will be refunded. Missing an appointment for which a deposit was paid will result in the deposit being forfeited.***

Procedure appointments: It is our policy to charge $100 for procedure appointments that are **not cancelled at least 24 hours in advance**. This fee cannot be billed to insurance and is the responsibility of the patient. Missing a procedure appointment without cancelling may result in dismissal from our practice.

Office appointments: New patients who miss an appointment may reschedule but after two missed appointments, the referring doctor's office must call to reschedule. Established patients may reschedule. Missing three appointments in a twelve month period may result in dismissal from our practice.

Special Fees

• Disability, FMLA and Miscellaneous forms	$25.00 ($10 to renew/update)
• Missed procedure appointments	$100
• Missed office appointments – not cancelled within 24 hours of appointment	$50
• Missed Appointment Deposit – after two missed appointments deposit is required to reschedule	$100
• Release of Medical Records – electronic copies sent to personal health record	No Charge
• Release of Medical Records – paper copies	$20 minimum (per IC 16-38-9-4)
• Returned checks	$30

If any unpaid balance is turned over to any attorney or collection agency, the patient will be responsible for court costs including reasonable attorney fees and accrued interest up to 8% annual under the FDCPA regulation.

I have read the Indianapolis Gastroenterology and Hepatology Financial Policy in full, and I understand and agree to this policy. I consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to Indianapolis Gastroenterology and Hepatology for any medical or endoscopic service furnished.

The patient's signature of the Notice of Consent / Financial Policy will be acknowledgement of this policy.

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Patient Signature | Patient Printed Name | DOB | Date