



## **Payment Policy for Bux-Mont Gastroenterology Associates**

1. **Insured Patients.** We do participate with many insurance plans and will gladly submit to them your information. **Co-payments are paid at the time of the service.** If you do not have your co-pay we will exercise our option to reschedule your visit. The co-pay is part of your contract with your insurer. You are responsible for your co-pay at the time of service. To not collect the co-pay is fraud on our behalf. Deductibles will be billed to you after notification from your insurer to this office. At that time payment is expected within 10 days of our statement. You must present a valid insurance card at the time of service. *Knowing your insurance is your responsibility.* You need to take the responsibility to contact your insurance company for the particulars of your coverage.
2. **Non-Insured Patients.** If you are not insured by a plan that we participate with or have no insurance coverage at all, *payment is expected at the time of your visit.* If you cannot make payment in full a minimum payment of \$50 for a consult/new patient visit is required prior to your seeing the doctor. **This will not be billed out for later payment you must pay prior to seeing the doctor.** A procedure requires a \$100 deposit. Both the \$50/\$100 is a deposit and is not the full amount that you are responsible to pay. We will gladly work with you on a payment plan.
3. **Screening Colonoscopy.** A colonoscopy is considered diagnostic when the patient is experiencing a symptom that requires further examination. A screening colonoscopy is done when there is an absence of symptoms or problems or your family physician has determined that this be done because of age or family medical history. A screening colonoscopy may fall under the wellness/preventive benefits of your policy, if this is the case some insurers are not covering this procedure. While we may obtain the pre-cert for this procedure it will only be covered if your policy includes it. This is very important that you personally look over your policy and that you call your insurer to make sure they will pay for this screening.
4. **Payment Methods.** We accept *Visa, MasterCard*, checks or cash. If you write us a check and it comes back 'marked insufficient funds' we will assess a \$30 charge to your account for reprocessing.
5. **Non-payment.** If your account is 90 days past due, you will receive a final letter stating that we will exercise our option to collect moneys owed to us either by turning the account over to Vision Financial Corp. or by filing a claim in small claims court if you do not respond in 10 days from the date of the letter. While we hesitate to do this we will pursue moneys owed to the practice. Also please be aware that if a balance remains unpaid you will be discharged from the practice for failure to make an honest attempt at payment. If this does occur you will receive notification by both regular and certified mail that you have 30 days to find other medical care.
6. **Changes in coverage.** It is your responsibility to notify this office of any changes in your medical coverage. Failure to do this may result in the entire amount of moneys owed being billed directly to you the patient. If your insurance has been terminated you are responsible for the entire amount owed.

***While our physicians are dedicated to your health care, you the patient must recognize that in order to continue serving you we must charge for services as they are delivered to you. It is your responsibility to pay for these services as they occur so that our physicians and staff may continue to serve you 24-7. Thank you.***

**I understand the payment policy in full and agree to the financial responsibility for myself/dependents for all medical services rendered thereof:**

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Signature of patient responsible party

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Today's Date