Paramount Surgery Center; GI Endoscopy Associates; Kentuckiana Gastroenterology; Summit Surgery Center
Anand(Andy) Gupta, MD, FACG
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NAME:_____ **BIRTHDATE** _____-_____-_____

ADDRESS:_____**CITY**_____**STATE**_____**ZIP**_____

HOME PHONE ( )_____-_____ **WORK PHONE ( )**_____-_____ **MARITAL STATUS M S W D**

CELL PHONE ( )_____-_____ **EMAIL** _____**SEX M F OTHER**

SOCIAL SECURITY NUMBER_____ **EMPLOYER**_____

EMPLOYERS ADDRESS _____

NAME OF SPOUSE (IF MARRIED)_____

PARENTS NAMES (IF PATIENT IS A MINOR)_____**CHILD LIVES WITH**_____

EMERGENCY CONTACT_____**PHONE NUMBER**_____

REFERRING OR FAMILY PHYSICAN_____**PHONE NUMBER**_____

PHARMACY NAME_____**PHONE NUMBER**_____

PRIMARY INSURANCE COMPANY_____**PHONE NUMBER**_____

ADDRESS_____

POLICY HOLDER_____**SOCIAL SECURITY NUMBER**_____**DOB**_____

RELATIONSHIP TO PATIENT_____**POLICY ID #**_____ **GROUP #**_____

SECONDARY INSURANCE COMPANY_____**PHONE NUMBER**_____

ADDRESS_____

POLICY HOLDER_____**SOCIAL SECURITY NUMBER**_____**DOB**_____

RELATIONSHIP TO PATIENT_____**POLICY ID #**_____**GROUP #**_____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THIS PRACTICE. I RECOGNIZE THAT I AM RESPONSIBLE FOR PAYMENT OF NON-COVERED SERVICES INCLUDING CLAIMS ISSUES RESULTING FROM OMISSIONS OR ERRORS ON THIS PATIENT INFORMATION FORM. I ALSO AUTHORIZE THE RELEASE OF ANY PERTINENT MEDICAL INFORMATION TO THE ABOVE NAMED INSURANCE COMPANIES TO ASSIST IN CLAIM PAYMENT. I AM AWARE THAT I WILL BE CHARGED A $25 FEE FOR MISSED OFFICE VISITS AND $200 FOR MISSED PROCEDURE APPOINTMENTS UNLESS I GIVE THE OFFICE 24 HOURS NOTICE.
I UNDERSTAND MY PATIENT RIGHTS AND RESPONSIBILITIES AND AM AWARE I CAN REQUEST A COPY OF THE HIPAA POLICY AT ANY TIME.

SIGNATURE_____**DATE**_____

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(502) 893-7744

PATIENT FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have questions about the policy, please ask to speak with our patient relations manager. We are dedicated to providing the best possible care and services to you and regard your understanding of our financial policy as an element of your care and treatment.

PLEASE INITIAL EACH LINE

____ • Payment for all services provided by our practice is due in full at the time services are rendered. Exclusions to this policy are those patients who are a member of a health care organization that we have a participating agreement with. We will bill your primary insurance plans for which we have an agreement and will only require you to pay the authorized co-payment, coinsurance, deductible or non-covered services at the time of service.

____ • Whenever you are having a procedure or surgery performed in the hospital, it is important to check if the facility also participates with your insurance company. It is the patient's responsibility to make this determination.

____ • If you are a member of a health care organization that our practice does not have a participation agreement with, we will prepare and submit a claim for you. This means your insurer will send the payment directly to you and the charges for your care are due at the time services are rendered.

____ • Medicare patients are responsible for their co-payments and any items deemed medically unnecessary by Medicare. In the event your health plan determines services to be "not covered" you will be responsible for the complete charges.

____ • If you are unable to pay for the visit at the time of service, please call our office prior to the appointment to arrange a payment plan.

____ • Patients will receive a monthly statement itemizing the services rendered and any unpaid patient balances. We will add a finance charge of 1.5% (18% annual fee) to any outstanding patient balance every month billed.

____ • For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

____ • We accept cash, personal checks, money orders, traveler's checks, MasterCard, Visa and Discover.

____ • A $25.00 NSF fee will be assessed to the account for every check returned to our practice for insufficient funds.

____ • Any collection fees will be the responsibility of the patient.

____ • Refunds will be issued to patient on a monthly basis. Refunds will be issued in the form of a check to those accounts paid with cash or check (after check has cleared the bank). Any payments made by credit card will be refunded directly back to the patient's credit card.

____ • We reserve the right to turn any patient over to collections if it is deemed that the account has been in default of the payment obligations or compliance of this policy. It is understood and agreed that we shall recover all costs and expenses, including attorney and court fees incurred in the collection of any such delinquent amounts.

____ • There will be a $10.00 charge for the completion of every form we are asked to complete by the patient.

I,_____ understand and agree to the provisions in this patient financial policy.

Signature _____ Date _____