Financial Policy Agreement

Digestive Disease Group / The Greenwood Endoscopy Center

This Financial Policy is an agreement between **Digestive Disease Group / The Greenwood Endoscopy Center (Creditor)** and the **Patient or Responsible Party (Debtor)** named below. By signing this document, you acknowledge and agree to the terms outlined below.

Financial Responsibility

You are responsible for the payment of all services received. This includes all amounts not covered by insurance, such as co-payments, deductibles, and non-covered services.

Monthly Statements

If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month. Depending on the service provided you may receive multiple statements:

- Digestive Disease Group, PA- Physician Fee, Anesthesia Fee and Technical component for Pathology.
- Viza Diagnostics- The professional component of pathology which includes reading and analyzing the biopsies/polyps.
- The Greenwood Endoscopy Center- the facility fee which covers equipment, staffing, and supplies.

Payment Terms

Due Date: Payment is due upon receipt of your statement. Balances not paid by the end of the month are considered past due.

Co-Payments: Insurance-required co-pays must be paid at the time of service. These cannot be billed to you later.

Payment Options

If you have insurance: You may choose to pay your deductible in full, and any out-of-pocket portions at the time services are rendered by **CASH**, **CHECK**, or **CREDIT CARD.**

If you have NO insurance or have Large Deductible: You may choose to pay by **CASH**, **CHECK**, or **CREDIT CARD** on the day that the appointment is scheduled. If you are unable to pay balance in full, we will accept a down-payment of **$75.00** on office visits, **$150.00** on consultations, and **$500.00** on procedures and will set up monthly payments equal to **10%** of the remaining balance.

Insurance

Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract, in most cases. We will bill your primary and secondary insurance companies as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from your insurance company.

No Surprises Act

I understand that I have the right to receive a Good Faith Estimate of expected charges if I am uninsured or self-pay. Additional information regarding my rights is available upon request.

Charges to Account:
We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Overpayments:
In the event of an overpayment or error in payment processing on your account a refund will be issued to patient or insurance.

Divorce:
In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a minor child will be the parent responsible for those subsequent charges. If the divorce decree required the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Past Due Accounts:
If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you may receive calls from a collection agent or by automation and you agree to pay all of the collection costs which are incurred. If we have to refer collection of this balance to a lawyer, you agree to pay all lawyer fees which incur plus all court costs. In case of suit, you agree the venue shall be in Greenwood, County, South Carolina. If your account remains past due, you may be required to pay the entire balance in full before scheduling any further appointments.

Missed Appointment Fee:
If a patient does not show up for a scheduled appointment, or cancels with less than 24 hours notice for office appointments or 48 hours on procedure appointments a fee will be charged. A fee of $25.00 will be charged for office appointments. A fee of $50.00 will be charged for consultation appointments. A fee of $100.00 for a colonoscopy or upper endoscopy procedure. This fee must be paid before a new appointment is scheduled. New patients who failed to keep their first appointment or established patients with more than (2) missed appointments will be seen only after approval from the attending physician.

Wavier of Confidentiality:
You understand if this account is submitted to an attorney or collection agency, if we have a litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you have received treatment at our office may become a matter of public record.

Co-Signature:
If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date:
Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Print Patient's Name:_____ Responsible Party: _____

Patient's Signature:_____ Date:_____