Frederick Gastroenterology Associates Financial Policy

Frederick Gastroenterology has implemented a secure web based credit card payment solution. We require a valid credit card on file for all patients. Your credit card information is stored in a compliant site which meets the payment card industry data security standards. Your insurance company will be billed charges for today and any future appointments. We also require a copy of your insurance card and photo ID at the time of your appointment.

If you are in an HMO plan that requires referrals, it is your responsibility to obtain the proper paper referral prior to your office visit. If you do not have your referral at the time of your appointment we will hold payment for 24 hours to allow you to obtain your referral.

If any elective procedure is to be performed, we do require that you pay any patient liability amount, according to your plan, in advance or immediately following your procedure. Payment in full is due in 30 days from the date of service.

Self-Paying Patients
Payment for services is due at the time of your appointment. We will be glad to arrange, in advance, any special payment requirements for our self-paying patients.

Appointment Cancellation Policy
Our Practice makes every attempt to provide quality care to our patients. New patient consultations are 30-minute appointments. We ask the courtesy of 24-hour notification if you are unable to keep your appointment. In the event that you do not notify us that you cannot make your scheduled appointment, you will be charged a $75.00 rescheduling fee. Established patients that fail to provide the above appointment cancellation notification will be charged a $50.00 fee. This payment is part of our office policy for non-cancellation of appointments and is not covered by your insurance.

We hope the above will help clarify your financial participation and enable us to better serve your medical needs. We urge you to discuss with Mrs. Page-Rough, our Office Manager, any special insurance needs or financial difficulties that may arise.

By signing this form you agree that any remaining allowed amount (Co-insurance or deductible) that is due as the patients' responsibility will be charged to your credit card on file unless an alternate method of payment is made at the time of service. If you have any prior outstanding balance, that amount will automatically be charged to your credit card unless you have made an alternate agreement.

______________________________	______________________________
Print Patient Name	Date of Birth
______________________________	______________________________
Patient Signature	Today's Date