SIERRA ENDOSCOPY CENTER, INC.
Andrew Chang, M.D., Aslam Godil, M.D., Roy Foliente, M.D., Dr. Hill, D.O.
FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

- Welcome to our office. Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy and Assignment of Benefits. We require that you read and sign prior to any treatment.
- All patients must complete the Patient Registration form prior to seeing the Health Care Provider.
- Fees for services, along with unpaid deductibles and co-payments, are due at the time of service. We accept cash, personal checks, VISA and MasterCard. Other payment options requiring financing can be arranged through our office and Medical creditors. All credit arrangements must be made prior to any provision of services.
- Returned checks are subject to an additional fee of $25.00.
- If you miss an appointment it is up to the physicians' discretion to charge the patient a $25.00 no show fee.

REGARDING INSURANCE

- If you have medical insurance, as a courtesy to you we will be happy to assist in the processing of your insurance claims. However, please remember that the financial obligation for medical treatment is between you and this office. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.
- We do accept assignment of benefits from your insurance company, but we ask that you pay your co-pay/deductible at time of service and set up a payment plan if needed.
- In the event your insurance company does not pay your balances in full within a reasonable period of time, we ask that you contact your carrier to help expedite the processing. If the insurance company does not pay in full within ninety (90) days, we require that you pay the balance due.
- Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due prior to treatment. In the event your insurance company changes to a plan where we are not participating providers, refer to the above paragraphs. In the event we are overpaid for a service provided, we will refund the overpayment.

USUAL AND CUSTOMARY RATES

- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.
- Not all services are a covered benefit in all Health Insurance Plans. Some insurance companies arbitrarily select certain services they will not cover. Some insurance plans base the amount of benefit on a chart or schedule of fees arbitrarily developed by third-party payers. This may cause you to receive a lower percentage of the reimbursement level indicated in your medical plan. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER

- I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare Assignment of benefits also apply.

ASSIGNMENT OF BENEFITS

- The undersigned hereby authorizes Sierra Nevada Gastroenterology Medical Associates, Inc., to request on my behalf and to collect directly any public and private insurance coverage benefits due. In the event payments for insurance benefits are paid directly to me, the undersigned, I will in turn, endorse over to Sierra Nevada Gastroenterology Medical Associates, Inc., all checks for such payments.

RELEASE OF INFORMATION

- I, the undersigned patient and/or responsible party, hereby jointly authorize this office, its agents/employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.
- I authorize release and disclosure of any and all of my medical records to any other entity, including but not limited to, referring physicians, hospitals, or other health care providers, which may be of assistance in the opinion of this office, in providing for the treatment of the patient.
- I authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled. I authorize this office and its employees to release, via facsimile machine, medical records which are needed in order to provide the patient with the most appropriate medical care.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Thank you for understanding our Financial Policy and Assignment of Benefits. Please let us know if you have questions or concerns. I have read the Financial Policy and Assignment of Benefits. I understand and agree to this Financial Policy and Assignment of Benefits form.

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Signature of Patient and/or Responsible Party **Date**