Troy Gastroenterology, P.C.

And its Affiliated Covered Entities: Center for Digestive Health, Macomb Endoscopy Center, and Surgical Centers of Michigan
Billing Department (586) 726-8423

HIGH COST DEDUCTIBLE HEALTH INSURANCE SUBSCRIBER

Procedure Policy

Patient Name: _____

Insurance: _____ Date: _____

As you are aware, there has been an ongoing trend in healthcare to have patient's shoulder a larger portion of their medical expenses, even with high quality insurance plans. In an attempt to keep insurance premiums from sharp increases, insurance carriers are creating plans that have large deductibles. A "deductible" means that before an insurance carrier pays for any expense, the patient will be required to pay a set amount of money out of pocket as determined by your insurance company. Insurance deductibles can range from $500 to over $10,000.

Our office has verified your insurance benefit. We were informed that your plan has a large deductible that has not yet been satisfied; therefore, your insurance will require that you pay that amount before your plan makes a payment on your behalf. Our contract with your insurance carrier obligates us to collect all patient responsibilities including deductibles.

Your plan deductible is _____. As of today, your remaining deductible is _____.

We do not know at this time the exact amount you will owe for your upcoming appointment; therefore, we will require that you place a credit card on file for payment of your patient responsibility as determined by your insurance carrier.

For your procedure, your insurance will be billed multiple claims.

Professional Fee: This is the fee from the Physician that performs your procedure. This will also include any laboratory or biopsy fees if applicable.
Facility Fee: This is the fee for the use of one of our surgical centers where your procedure will be performed.
Anesthesia Fee: This is the fee for services provided by our Certified Registered Nurse Anesthetists.

We ask that you fill out the attached form and present it at the time of your procedure. Once the insurance company notifies us of your patient responsibility, we will process your credit card for payment.

If you have questions or concerns, please feel free to contact our billing department at (586) 726-8423.

Thank You,

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Patient Name _____ Patient Acct #_____

Scheduled for_____ on _____ at _____ with Dr. _____

Please complete the information below and return it on the day of your procedure:

I, _____, authorize Troy Gastroenterology, Anesthesia MEC/SCM, and Surgical Centers of Michigan or Macomb Endoscopy Center to charge my credit card below for:

☐ Deductible, coinsurance or other out of pocket expenses as determined by my insurance for the professional, facility and anesthesia charges associated with the above listed procedure.

☐ An initial charge to my credit card of $300.00. I understand that any remaining balance will be due within 60 days of the procedure unless payment arrangements are made. If the balance is not paid within 60 days, our standard collection process will apply.

Billing address:_____ Phone #:_____

City, State, Zip:_____ Email:_____

Special instructions: _____

Please present your credit card to receptionist on the day of your procedure. It will be stored in our secure encrypted billing system until your insurance informs us of your responsibility. An email receipt will be sent upon processing.

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Signature Date

INTERNAL USE ONLY:

Billing ID Codes Facility _____ Anesthesia _____ Troy Gastro _____