OFFICE AND FINANCIAL POLICY

OFFICE HOURS:

Regular office hours are 8:30 a.m. to 5 p.m. Monday through Friday. Office visits are by appointment only. We strongly believe in the value of your time and will do our best to keep your scheduled appointment running smoothly. However, emergencies do occur and may cause a delay.

TELEPHONE CALLS:

All offices share the number (248) 844-9710. Please listen to all prompts and our phone system will direct you to the area of your choice. Our physicians utilize designated Medical staff to return patient calls with their recommendations. If you have a question for your physician, listen through all the prompts and you will be automatically directed to the nursing staff. Non-urgent calls will be returned within 48 hours. Prescription refill request will be processed within 72 hours. The telephone system is shut down at 4:30 p.m. to facilitate return calls to patients.

FEES AND PAYMENTS:

Our practice is committed to providing you with the best possible treatment and we charge what is customary in our area. Full payment is expected at the time of service by cash, check, Visa, MasterCard, or Discover, unless arrangements are made prior to your visit with our billing department. As of January 1st, 2016, a $5 service fee will be charged for any office visit copay that is not paid at the time of service.

***MINOR PATIENTS*:**

Several of our physicians will begin treating patients at the age of 16. The parent, guardian, or other adult accompanying a minor is responsible for payment. An unaccompanied minor must provide a permission note authorizing service and a telephone number where a parent/guardian may be reached.

***REMICADE RESPONSIBILITY*:**

It is your responsibility to provide the office with current active insurance information. You will be responsible for any out of pocket expenses. Payment will be expected at the time of service unless special arrangements have been made with the billing department. We require account balances to be paid up to date to avoid any disruption in the treatment schedule.

INSURANCES:

Troy Gastroenterology participates with many insurance plans, including Medicare, BCBS and select HMO, PPO and commercial plans. We follow the rules and guidelines of these plans. If you have insurance coverage, please understand that your policy is a contract between you and the insurance company, not the practice and the insurance company. Patients should be aware of the following prior to their appointment:

- Verify that our physicians are contracted with your insurance plan.
- Familiarize yourself with the out of pocket expenses associated with your insurance plan. These can include copays, coinsurance and deductible requirements. You are responsible to pay these amounts according to your contract benefits.
- Not all services are benefits under all contracts. It is the patient's responsibility to know their coverage. Note that some screening procedures may not be covered. We suggest you contact your insurance company prior to your visit to get coverage details. A covered service remains subject to any applicable copay, coinsurance and deductible requirements. Any charge not covered by an insurance plan becomes the patient's responsibility.
- Many HMO insurance plans require a referral or authorization for service. The patient is responsible for obtaining any necessary office visit referrals per the rules of their insurance. If a necessary referral cannot be confirmed 24 hours prior to the appointment, we will be required to reschedule the appointment. Our billing department will assist you in obtaining necessary authorizations for procedures and diagnostic testing.

Please refer to our website for a complete description of our financial policy.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of medical health benefits to Troy Gastroenterology, P.C., and/or Surgical Centers of Michigan/Macomb Endoscopic Center, LLC for services rendered under the supervision of a physician and/or nurse. I authorize any holder of medical or other information about me to release to the health insurance company any information needed to determine these benefits for related services. I understand that I am financially responsible for any balance not covered by my insurance.

I certify that the demographic and insurance information given by me in applying for payment is correct.

Patient Name (Print) _____ Signature _____ Date _____

Guardian Name (Print)_____ Signature _____ Date _____

Witness (Print) _____ Signature _____ Date _____

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