Troy Gastroenterology, PC
Sante D. Bologna, M.D., FACP
John R. Weber, M.D.
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Surgical Centers of Michigan, LLC
M. Emin Donat, M.D., FRCPC
Leonard G. Quallich, M.D.
Anezi E. Bakken, M.D., MS

Macomb Endoscopy Center, PLC
Wael H. Refai, M.D.
Kerri A. Bewick, D.O.
Amir Abadir M.D., FRCPC

Billing Department (586) 726-8423

CASH/PROMPT PAY AGREEMENT

Date_____ Patient_____

In an effort to help keep healthcare affordable for residents of the tri-county area, our office offers a discounted fee schedule for patients that do not have ANY insurance coverage for medical care. Patients with any type of medical insurance plan are not eligible for these discounts based on our contractual agreement with those insurance companies.

In order to qualify for this discounted rate, patient must meet these four conditions:

1. The patient must not have any insurance coverage for medical bills.
2. The patient must agree to the terms of this document by signing below.
3. The patient must pay the discounted rate specified below prior to or at the time of service.
4. The patient must agree that once the discount has been received, our office will not at any time, submit a claim to an insurance carrier. This also applies to retroactive coverage.

You are scheduled on _____ for a _____with_____.

For an office visit appointment, you will be asked to pre-pay:

☐ $200* New Patient Cash Pay Deposit

☐ $100* Established Patient Cash Pay Deposit

*The actual charge will be determined based on level of service. A 25% discount will be given off the actual charge.

☐ The discounted fee for your scheduled procedure is_____**.

**Procedures have a set fee schedule. In rare instances, the physician may have to do an additional procedure that can increase your responsibility. You will be billed for any additional services.

You will be expected to pay this amount at your scheduled appointment upon check in. You may also call our billing department at (586) 726-8423 in advance of your appointment to pay by credit card.

Please sign below and bring this document along with your payment to your appointment.

I acknowledge that I have no current medical insurance coverage. I understand that I am receiving a discounted rate and agree to pay for services provided to me by either Troy Gastroenterology PC, Surgical Centers of MI or Macomb Endoscopy Center on the date the service is provided.

Patient Signature_____Date:_____