ASSOCIATES IN DIGESTIVE HEALTH
UNITED DIGESTIVE PARTNER PRACTICE

ENDOSCOPY
FINANCIAL DISCLOSURE STATEMENT

Date _____ Procedure _____

Patient Name _____ Date of Birth _____
(please print)

Thank you for choosing to have your procedure at one of Associates in Digestive Health's affiliated Endoscopy Centers. Please read and sign this Financial Disclosure Statement prior to your procedure. Patients who do not pay in full at the time of service must complete the required information and insurance forms before service will be rendered.

You can expect to receive the following bills as a result of services provided:

- **Physician Fee[1]:** Fee to be paid to the physician for performing the service. This bill will be from Associates in Digestive Health, LLC or United Digestive Florida.
- **Facility Fee:** Fee for the use of the facility for the surgical procedure and service overhead, including facility staff, equipment, supplies, etc. This bill will be from Associates in Digestive Health, LLC.
- **Pathology Fee[2]:** If a tissue biopsy is required, there will be fees for pathology. Specimens are sent to labs based on insurance or specific conditions and may be billed in two separate components: professional and technical. The bills will come from the facility (technical) where the pathology is processed and/or from the pathologist (professional) who examines the specimen(s).
- **Anesthesia Fee[2]:** Fee to be paid to the anesthesia group to cover anesthetic and vitals monitoring. This bill will be from West Florida Anesthesia Associates, Anesthesia Dynamics, LLC, Gastroenterology Anesthesia Associates, LLC or Gulfshore Anesthesia.

Some insurance companies require precertification for this service. We will make every effort to verify your benefits and obtain any necessary precertification prior to your appointment. This is not a guarantee of payment.

Your insurance company will send you an Explanation of Benefits that will explain how your bill was paid by them and any amount for which you may be responsible. It is your responsibility to understand your insurance benefits.

Some insurance plans require you to pay different out-of-pocket amounts based on the location at which the service is performed. Deductibles, co-insurance and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. We will submit primary, secondary and tertiary claims on your behalf as long as the information needed to process the claim is received and verified before your procedure. If this information is obtained after your visit or if the information provided is deemed inactive for your dates of service, the patient or guarantor is responsible for the balance.

We accept cash, checks and major credit cards. Associates in Digestive Health and its affiliates collect copayments at the time of service. Additional payment may be required based on your insurance plan. If you have a balance due at any affiliate of Associates in Digestive Health, LLC, your payment may be applied to the oldest balance first. In the event your account has a credit for one affiliate and a deficit for another, we reserve the right to transfer credits to any outstanding balances prior to issuing a refund.

Questions regarding billing or payment arrangements should be directed to the business office by calling 239.275.8882.

If you are unable to keep your appointment, please reschedule at least 48 hours in advance. A missed appointment will result in a $75 fee. A $30 fee will be incurred for returned checks.

PATIENT'S REASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand the billing practices of Associates in Digestive Health, LLC and their affiliates and that I may receive multiple bills related to my service as explained above. I authorize payment of medical benefits to Associates in Digestive Health, LLC and their affiliates and authorize them to release any medical information necessary to process claims. I give Associates in Digestive Health, LLC permission to apply payments received to balances due at Associates in Digestive Health, LLC or any of their affiliates, and understand that payments may be applied to the oldest balance first. I understand that I am financially responsible for any co-payments, deductibles, co-insurance and non-covered services as outlined by my health plan.

_____ Date _____

*Patient/Authorized Representative Signature *If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

_____ Date _____

Witness

[1]If the physician performing your procedure is a member of another practice, the bill will come from their practice entity.

[2]We may contract with third party providers/facilities for anesthesia and pathology services. Your insurance plan may or may not consider these providers/facilities as in-network. It is up to you to understand your individual insurance benefits.