Patient Financial Responsibility Agreement

(Rev. 2/29/09)

In order for Carolina Digestive Health Associates P.A. to continue providing our patients with quality medical care, we must receive the contracted payment for our services. Ensuring that we are appropriately and promptly paid is our PATIENTS' RESPONSIBILITY.

As a patient of Carolina Digestive Health Associates, you are hereby agreeing:

- ***To Pay all non-insured charges***, including your co-pay, co-insurance, insurance deductible, out-of-network charge differential, and all other non-covered charges at the time of service or when otherwise advised.

    ******If this is not possible, you agree to contact our Business Office BEFORE services are rendered.***

- To Provide us with a copy of your most recent insurance card or other Proof of insurance at the time of **EACH** service, including hospital-based services.
  If you do not provide us with valid insurance information at the time of EACH service, you agree to personally pay all unpaid charges.

- **To Obtain any required authorization under your insurance plan for our services from your primary care physician and/or your insurer prior to each appointment.**
  If you do not receive the required authorization, your insurer may not pay us for our services. In these cases, you agree to personally pay any resulting unpaid charges.

- ****To Monitor your insurance company's payment of your account and, if unpaid within 60 days from the date of service, to contact them regarding non-payment, and to cooperate with CDHA to resolve the unpaid status of your account.*

- ***We charge a $25.00 fee to patients that do not arrive for their appointment or do not provide adequate notice. We will also charge $100.00 for failure to show for a procedure or not providing adequate notice.***

Further, you agree that your physician and Carolina Digestive Health Associates P.A. has the right to be paid for their services and you acknowledge:

- **That unpaid bills older than 90 days from date of service may be turned over to a debt collection agency or attorney for collection.**
- **That you will be responsible for any resulting collection fees, including reasonable attorney fees, and/or bank fees incurred as a result of a returned check.**

Patient or Guarantor
Signature____Date_______________________
By my signature, I am indicating that I have read, understand and agree to the above provisions.

No form may be altered without express permission.