



Advanced Gastroenterology, P.C.

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Non-Insured Patient Payment Policy

Patients who are not eligible for insurance benefits are considered "Private Cash Pay." If you do not have insurance Advanced Gastroenterology will provide your care on a cash for services basis.

A \$150 co-pay is due at the time of the visit for all **office** visits. A \$500 deposit is due prior to any **procedure** being performed. Patients will be billed for any remaining balance.

A surgical estimate will be prepared for the patient. Please note that there may be an additional amount owing if there are any additional services performed during procedure.

Patients who wish to pay in full at the time of service are eligible for a 15% discount. This discount is given due to the fact that our office does not have to take on the responsibility of billing the insurance company or the patient.

Any check returned for non-sufficient funds will be deposited a second time. If the check is returned a second time, the patient's account will be charged a \$35 fee to cover the clinic's costs. You will be advised of this charge by letter.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I, the undersigned, agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of services.

Patient's Name (please PRINT): _____

Patient's Signature: _____ Date: _____

If patient is under the age of 18 years, or is otherwise unable to sign, complete the following:

Patient is _____ year(s) of age or is unable to sign because: _____

Patient's Name (please PRINT): _____

Signature of Responsible Party: _____ Date: _____

Relationship to patient: _____