



ADVANCED GASTROINTESTINAL SPECIALISTS, P.C.

Leading the way in experienced, compassionate & results-driven care.

PATIENT REGISTRATION

Welcome to our practice. We are pleased that you have chosen our office for your gastrointestinal care. All the physicians in this practice are Board Certified in the areas of Internal Medicine and Gastroenterology. We are practicing our specialty together to give you the best medical care when you need it and hope that you feel comfortable and secure with the treatment.

Enclosed, please find a copy of our patient registration forms. We ask that you have all the registration forms completed and signed prior to your visit. Please make sure that you bring these completed forms and all current insurance cards with you for your visit. If your insurance requires a referral form or specialist co-pay, they will also be collected at the time of service. If you have any questions concerning these forms, please feel free to call our office during the hours of 9:00am to 5:00pm and we will be happy to assist you the best we can.

Please bring all pertinent blood and x-ray results with you for your visit.

This appointment is for a Consultation only. No procedures will be done at this visit.

We appreciate that you have chosen Advanced Gastrointestinal Specialists for your care and look forward to taking care of your special needs.

Your appointment is scheduled for _____ at _____ AM/PM

in our _____ office with Dr. _____



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PAYMENT POLICY

Thank you for choosing us as your Gastroenterology provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit or with-in **14** days of the billing statement. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage or with-in **14** of the billing statement. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services at the time of service or with-in **14** days of billing statement.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Initial _____



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6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in **60** days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over **30** days past due, you will receive a letter stating that you have **14** days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to IC SYSTEM, a national Collection Agency authorized to credit report all outstanding debts to the four National Credit Agencies, litigate in a court of law (other legal fees may apply) and charge a service fee of **\$30.00**.
8. **Additional Cost of Collection Services.** Billing statements shall be deemed to be accepted by you unless **Advanced Gastrointestinal Specialists** is notified in writing within 14 days of the invoice being issued that you dispute the amount of the statement. In the event of non-payment, **Advanced Gastrointestinal Specialists** may in addition to the invoice amount charge:
 - a. Interest on any outstanding amounts from the due date calculated at the statutory penalty rate of New Jersey's Established Interest Rate.
 - b. Legal and collection fees incurred by **Advanced Gastrointestinal Specialists** in relation to recovery of outstanding amounts.
9. **Missed appointments.** You may be charged for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment or call **48** hours prior to cancel – scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary fees for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party

Date