Regional Digestive Consultants, P. A.
Premiere, patient centered digestive care

Phone: 281-528-1511
Fax: 281-419-8485
www.rdctx.com

Office & Financial Policy

Regional Digestive Consultants, P.A. strives to render excellent medical care to you and the rest of our patients. In order to provide the highest quality medical care we must insure that we meet the expenses necessary to operate this facility. We provide you with this agreement to acquaint you with our financial policy.

_____ (Initials) **Insurance:** When making an appointment, it is your responsibility to confirm with your insurance company that Dr. Shailaja Behara is currently under contract with your plan.

_____ (Initials) **Self Pay/Non-Contracted Plans:** All charges are due and payable at time of service. We accept cash, checks, debit, and major credit cards. We may reschedule the appointment if payment is not made prior to the services rendered.

_____ (Initials) **Insurance Responsibility:** The patient is responsible for knowing their insurance benefit coverage and whether a referral is needed. We will file your insurance claim on your behalf. We allow 45 days from the date a claim is filed for the insurance company to pay. If the insurance carrier does NOT pay within this time, you will be responsible for the entire balance**. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria such as deductibles, non-covered services, co-insurance, pre-existing conditions or "reasonable and customary charges", etc. other than to supply factual information when necessary.** You are responsible for timely payment of your account. Patient deductibles, co-insurance, and copayments are established by your health plan and are due at the time of service.

_____ (Initials) **After Insurance Pays:** Any remaining balance after your insurance pays is **due in 30 days** regardless of whether or not you receive a statement from Regional Digestive Consultants, P.A. Statements are sent out monthly. You have access to your Explanation Of Benefits from your insurance company either online, by telephone, or mail. Your EOB will show the amount you owe to the physician.

_____ (Initials) **Insurance Filing:** We will file your primary and secondary insurance for you as a courtesy if the following conditions are met:

1) The Assignment of Benefits has been signed and 2) Primary and secondary insurance information has been provided to us at the time of the visit.

PATIENTS WHO FAIL TO PROVIDE INSURANCE INFORMATION ARE DIRECTLY RESPONSIBLE FOR PAYMENT OF THEIR ACCOUNT.

_____ (Initials) **Check-In/Check-Out:** Please bring your current insurance card with you to **EACH VISIT**. **On follow-up visits**, you will be required to verify demographics and insurance information so that our records remain up-to-date. **Please be prepared to pay for your current visit as well as any past balances** in your account. You will not be seen if you have an unpaid balance. **We will collect your copay, deductible, or coinsurance at the time of service.** We accept cash, check, debit, major credit cards.

_____ (Initials) **Delinquent/Unpaid Accounts:** Accounts which cannot be collected by the physician after normal, in-house collection procedures may be referred to a collection agency, magistrate, or attorney for further collection action in accordance with the physician's established guidelines. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing. It is your responsibility to contact our business office if there are extenuating circumstances regarding your account before your account is turned over to an outside collection agency.

_____ (Initials) **Refunds:** Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients' refunds will not be processed **until all active or past due balances are paid in full.**

_____ (Initials) **Third-Party Litigation:** Our physician will not be involved in disputes arising from third-party claims (i.e. auto accidents, liability claims.)

_____ (Initials) **Insurance/Disability forms:** There will be **a $25 handling fee** for writing a letter or filling out claims forms, such as insurance, FMLA, and disability forms (excluding Medicare patients). The fee is due once the form is completed, and the patient is directly responsible for this fee.

_____ (Initials) **Returned Checks:** Checks returned to Regional Digestive Consultants, P.A. for insufficient funds, closed account, stopped payment, or for any other reason will be subject to **a $35 fee.**

_____ (Initials) **Medical Records:** A **fee of $25** will be charged for the first twenty pages and **$0.50 per page** for every copy thereafter. Requests will be completed within ten (10) business days

_____ (Initials) **No Show/Late Cancellations:** We request that you give our office **advance notice 24 hour/1 business day** *for office visits* and **48 hour/ 2 business days** *for procedures* if you must cancel/reschedule an appointment. If you change on the same day as your appointment, you will be considered a NO SHOW for that day**. If you are a NO SHOW or late cancellation for office visits, a $25 fee will be charged. Procedure and Surgical NO SHOWs will result in a $75 fee. This fee will not be applied to deductible or co-pay or co-insurance**.

_____ (Initials) **3 Cancellations/reschedules:** If patient cancels or reschedules three appointments in a row, our office will terminate your doctor/patient relationship and you will need to find another physician to continue your medical care.

_____ (Initials) **Minors:** The parent or guardian accompanying the minor is responsible for providing current information for the minor and/or payment in full for services provided.

_____	_____	_____
Printed Name	Signature of Patient or Personal Representative	Date

SCREENING COLONOSCOPY (Please sign this form if you may need to schedule a screening colonoscopy.): Patients who have screening examinations have no signs or symptoms, and have a separate benefit from their insurance company. If the physician performing your procedure finds a polyp or abnormality, your benefits may change and your insurance policy will pay differently and the colonoscopy **will no longer be considered a "screening"** procedure and it is considered a surgical or "diagnostic".

I acknowledge that I have read the above statement and will be responsible for my deductible, copay, and out-of-pocket expenses in the event that my scheduled screening examination does result in a diagnostic procedure.

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_____ _____

Signature of Patient or Personal Representative Date