Payment Practices & Procedures

- **Self-pay**: Payment is due in full at the time of service unless arrangements have been made with the Digestive Healthcare Billing Office.
- **Insurance**: Our office will submit your insurance claim. Insurance companies rarely provide full coverage for endoscopy procedures, therefore your co-pay is due at the time of service. Medical insurance is an agreement between the patient and insurance carrier—the patient, not the insurance company, is ultimately responsible for the payment to this office. If the patient is a minor, payment is due from the parent/guardian who accompanies the minor to the office. When payment is received from the insurance company, you will receive a statement for the balance or a prompt refund if a credit exists.
- **Social Security Number:** Disclosure of your social security number is voluntary. However, failure to do so may require our office to have payment in full for services at the time they are rendered.
- **Payment For Services** For your convenience, we accept cash, VISA, MasterCard, and AMEX, debit cards, traveler's checks, money orders and personal checks. Starter checks and post dated checks are not accepted. A valid picture ID is required on all checks. **If co-payments, coinsurances and/or deductibles are required by your insurance plan, they are due when services are rendered.**
- **Cancellation/No Show Policy** To ensure that all our patients have access to our physicians, we have established the following fees for **late cancellations** and **no shows.** Procedures cancelled less than 72 hours of the appointment may be subject to a charge of **$100.00**. These charges will be billed to the patient and not their insurance carrier.

Notice of Privacy Practices
The Privacy of Your Health Information Is Important To Us

We support your right to privacy of your health information. We are required by applicable federal and state law to maintain the privacy of your health information and to provide you with this notice about our privacy practices, our legal duties, and your rights concerning your health information. We reserve the right to make changes in our privacy practices for all health information we maintain. You may request a copy of our privacy notice at any time.

Your health information is used for planning of care and treatment, for communication among healthcare professionals involved in your care, for billing purposes, and for assuring quality of care.

By signing below I acknowledge

1. I have been informed of Summit Endoscopy Center's Privacy Practices and have been given time to review them and/or receive a copy.
2. I understand Summit Endoscopy Center's Payment Policy.
3. I have received information concerning advance directives, patient's rights and financial disclosure prior to my procedure.
4. I authorize my driver to be present in recovery during the discussion of my procedure results.

Signature: _____ **Date:** _____

Date of Birth: _____