

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT

Gastroenterology of Southern Indiana, P.C. ("GSI")
Southern Indiana Endoscopy, L.L.C. ("SIE")

HIPAA Privacy Notice

Acknowledgment of Receipt

This is to acknowledge my receipt of the HIPAA Privacy Notice delivered to me by GSI/SIE.

Patient Name (Please print)

Social Security Number

Signature of individual or personal representative

Personal representative (Please print)

FOR INTERNAL USE ONLY

(If No Patient Signature, GSI OR SIE Fill Out Below)

RECORD OF GOOD FAITH ATTEMPT TO DELIVER

This is to record my good faith effort to obtain a written acknowledgment of receipt of the HIPAA Privacy Notice to:

Patient's Name: _____

Date: _____

SSN: _____

Acknowledgment of receipt of the Privacy Notice from the patient named above was not obtained for the following reason(s).

GASTROENTEROLOGY OF SOUTHERN INDIANA, P.C.
SOUTHERN INDIANA ENDOSCOPY, L.L.C.

Signature

Name

Title: _____

Date: _____

GASTROENTEROLOGY OF SOUTHERN INDIANA, P.C.

PATIENT FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible care and to your treatment being successful. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your treatment. We accept Cash, Check, Money Order, Visa, Mastercard and Discover.

INSURANCE

Our practice is committed to providing the best treatment for our patients. We must emphasize that as Medical Care providers, our relationship is with you, our patient, not with your insurance company. We cannot accept the responsibility of negotiating the claims with insurance companies or any other persons. While the filing of insurance claims is a "courtesy" that we extend to our patients, all charges are your responsibility from the date of the services rendered.

Your insurance coverage is a contract between you and your insurance company. It is very important that you understand the provisions of your policy. We cannot guarantee payment of claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policyholder. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Some of the services may be considered "non-covered" services and not considered necessary under Medicare and other medical insurance programs. Please remember that professional services are rendered and charged to the patient, not the insurance company.

We charge what is usual and customary for our area. The patient is responsible for payment in full within a reasonable time – regardless of the status of the claim or any insurance company's arbitrary determination of usual and customary rates. Our fees are considered to fall within the acceptable range of most companies and therefore are covered up to the maximum allowance determined by each carrier.

If you have a managed care medical insurance that we participate with, your payment of deductibles, non-covered services and co-payments are due when services are rendered. If we do not participate with your insurance company or if you do not have health insurance coverage, payment in full for services is due at the time services are rendered.

Although an insurance claim is filed, you will receive a monthly statement if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. The patient is responsible for payment.

If you would have a procedure by any one of our physicians at Southern Indiana Endoscopy, LLC, (SIE) our ambulatory surgical center, you will receive a bill from SIE for a facility fee and GSI for a physician's fee. Any biopsies will be billed separately by the pathologist.

In the event that you cannot pay your balance in full, we encourage you to contact our financial department for assistance in the management of your account. If your account becomes delinquent and you have not responded to our collection efforts, your account may be turned over to an outside source for collecting the balance due, and at which time you will be responsible for all fees related to that expense.

RETURNED CHECKS

Any returned checks are subject to a \$35.00 service fee. Any returned check must be resolved before any future appointments can be arranged.

MISSED/RESCHEDULED APPOINTMENT POLICY (Effective November 1, 2009)

We make every effort to strive for excellence in our specialty and in our profession. An important aspect of providing quality care is to be respectful of your time and make every attempt to accommodate your scheduling needs. To accomplish this, it is very important to be on time for your appointment, arriving early for paperwork, and to notify us in the event you need to reschedule this appointment. We reserve an ample amount of time for our patients because we feel it is important in providing quality health care. Therefore, sufficient notice to change your appointment is necessary in order to accommodate your needs and to have the opportunity to offer this time to another patient.

Due to the increasing number of "no show" patients, we have made the difficult decision to assess a "no show" fee to patients who simply do not show for a previously scheduled appointment. We greatly appreciate your consideration in calling us **at least 2 business days prior** to your scheduled appointment for any cancellations or rescheduling needs. **Appointments that are not cancelled/rescheduled by 12:00 noon the day prior to your appointment will incur a \$25.00 charge.** It is our sincere hope that this will not be necessary.

Please Note: This charge is not covered or paid by any insurance company; therefore, the charge will be billed directly to the patient. This fee must be paid prior to being seen for any rescheduled appointments.

To reschedule or cancel an appointment, please call our appointment line directly, (812) 206-7073. If the appointment scheduler is with a patient, please feel free to leave a message on her voice mail. Your call will be promptly returned if necessary.

MINOR AGE PATIENTS

For unaccompanied minors, treatment will be denied unless charges have been pre-authorized prior to date of service. The adult accompanying a minor and the parents or guardians are responsible for payment in full.

MEDICARE, MEDICAID, PRIVATE INSURANCES

If you are covered by one of the above, or any other government sponsored program, you must present your current insurance card prior to services being rendered. If your card is not available, we will be happy to reschedule your appointment.

WORKMAN'S COMPENSATION, AUTOMOBILE ACCIDENTS

If you are covered by one of the above, we do not file on these services and payment in full is due at time of service, although we will provide you with any information that you may need to file for these services on your own.

FMLA/DISABILITY FORMS **(Effective November 1, 2009)**

Gastroenterology of Southern Indiana, P.C. will charge \$35.00 for each FMLA and/or disability form we complete. These fees must be paid prior to the forms being complete.

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

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

- I have read and understand the "no show" policy fee which will be assessed to me, the patient, if I do not call to **cancel/reschedule by 12:00 noon the day prior to my appointment and will incur a \$25.00 charge.** I further understand this fee must be paid prior to being seen for any rescheduled appointments.

Patient or responsible party

Date

Patient Name (Print)

Date of Birth