



Payment Policy and Agreement

Patient: _____

Chart #: _____

Dr: Waller Smith Chilukuri Arruffat

Our commitment to our patients is to provide quality, affordable healthcare. In order to succeed we need your assistance and understanding of our payment policy.

You will be financially responsible for all charges on your account with *Ohio Valley Colon & Rectal Surgeons*, including but not limited to, co-payments, co-insurance, non-covered services, and deductibles. **Insurance co-payments are due at check-in on the date of service. If you are unable to pay co-payment, you will be asked to reschedule your appointment.**

As a courtesy, *OVCRS* will contact your insurance company to obtain Authorization, or Pre-certifications for procedures scheduled by our office. Please remember that authorization or pre-certification **does not guarantee coverage with your insurance**. It is the patient's responsibility to contact the insurance carrier prior to all services rendered, for determination of benefits and to know and understand the expected out of pocket expenses you may occur.

Patients with high deductible plans, \$1000 or more, will be expected to pay a portion of approved fees prior to services rendered. Routine screening procedures will be expected to pay 1/2 of approved charges and non-routine procedures will be expected to pay 1/3 of approved charges. You will be contacted by our business office if prepayment is required. There will be facility charges in addition to the physician's fee for all procedures done outside *OVCRS* office. **The patient is responsible for making separate arrangements with the facility for payment of those charges.**

Uninsured/self-pay patients will be asked to make payment in full unless prior arrangements are made in advance of services rendered. Please ask to speak to a member of our insurance staff to inquire about payment options that are available. **We do offer some interest free financing options for patients that qualify.**

Disability/Family Medical Leave Act forms will be filled out for the **Patient** at no cost. Any additional forms for patient or family members will be charged a fee of \$5.00 per form.

We accept cash, check, MasterCard and Visa. You will receive a monthly statement on your account for any balance due and payment is expected upon receipt of statement. If payment is not received on account within 60 days, collection process may be initiated.

Payment Agreement

As the Patient or Patient Authorized Representative and Responsible Party, I hereby understand the payment policy and agreement set forth by *OVCRS*. I also request that payment of authorized insurance benefits (including, but not limited to Medicare, Medicaid, HMO, PPO, BC/BS and Workers Compensation) be made on my behalf to *OVCRS* for any services furnished to me by physicians or employees of *OVCRS*. I authorize any holder of medical or other information about me to release to my insurance company and its agents any information needed to determine these benefits or benefits for related services. I request that any other insurance benefits be paid directly to *OVCRS*. I authorize *OVCRS* to submit claims to my insurance carriers or their intermediaries for all services rendered by *OVCRS*. I authorize the release of any information required to process any claims. **Notice of Privacy Practices available upon request or visit our website at www.colonsurgeons.com.**

I understand that I am financially responsible for all balances regardless of insurance coverage, if any, subject to Federal Law concerning payment for services provided to Medicare beneficiaries. I also agree to be responsible for reasonable attorney's fees, court costs and other collection expenses incurred by *OVCRS* in connection with collection of amounts due.

Patient Name (print)

Patient Signature/Patient Authorized Representative

Date: _____

White copy (Office use)

Yellow copy (Patient)