Practice Financial Policy and Patient Agreement

This Financial Agreement ("Agreement") is made between Riverside Digestive & Liver Health Clinic ("Clinic") and the undersigned patient ("Patient").

1. Payment for Services

- The Patient agrees that the Patient is ultimately financially responsible for all services rendered by the Clinic, including but not limited to consultations, tests, procedures, and any other services provided. The Patient understands that the Clinic may bill for these services based on the established fee schedule.

2. Insurance Verification, Billing, and Patient Responsibility

- The Patient understands that the Clinic may submit claims to their insurance provider(s) on behalf of the Patient. The Patient is responsible for providing accurate insurance information.
- The Patient agrees to pay any balance due or amount not covered by insurance, including but not limited to deductibles, co-pays, or co-insurance amounts, as well as any charges for services that are not covered by the Patient's insurance plan. If there is no insurance, the Patient is responsible for the full amount due at the time of service.
- If the Patient's insurance policy requires a primary care physician referral, prior approval, or other pre-authorization in order for the Patient to receive services, it is the Patient's responsibility to ensure that the necessary referral is current and has been presented to the Clinic prior to receiving services. If no required prior approval or pre-authorization is presented in advance, or if no such authorization is required, the Patient will be personally responsible for payment for any services rendered to them by the Clinic (including all affiliated providers).
- At the time of service, the Patient, as the insured, must pay any and all deductibles and/or copays. The Patient may also be responsible for payment of any claim that is “denied”, “unpaid due to deductible”, “partially paid”, “partially paid due to the insurance carrier’s arbitrary determination of usual or customary rates” or “coinsurance”
- If the Patient’s claim is involved in litigation and/or is being disputed among insurers, the Patient remains financially responsible. The Patient must pay any balance that their insurance carrier designates as their responsibility. It is also the Patient's responsibility to notify the Clinic of any changes in coverage or insurance plans as soon as those changes occur to avoid delays in care or services rendered.

- The Patient is ultimately responsible for verifying coverage or benefits of the Patient's insurance. Although Clinic will assist the patient, however Clinic is not responsible for verifying the coverage or benefits of the Patient's insurance, nor is the Clinic liable for any incorrect information given by the insurance company. The Patient is responsible for determining whether their insurance plan covers the services provided by the Clinic. The Clinic recommends that the Patient verify their insurance coverage prior to receiving care.

3. Financial Assistance and Payment Plans

- The Clinic may offer payment plans or financial assistance programs for eligible patients. The Patient agrees to discuss any financial concerns or request assistance with the Clinic's management. Any arrangements for payment plans must be agreed upon in writing.

4. Payment Methods

- Payments for services rendered by the Clinic may be made through various methods, including but not limited to credit/debit cards, checks, and cash or other third party financial services.

5. Missed Appointments and Cancellation Policy

The Patient agrees to notify the Clinic at least [48] hours in advance for cancellation or rescheduling of appointments to avoid a missed appointment fee. If the Patient fails to cancel or reschedule an appointment with the required notice, the following fees may apply:

- **$100 fee** for missed clinic appointments
- **$500 fee** for missed procedure appointments

The Clinic reserves the right to charge these fees if the Patient does not cancel or reschedule within the specified time frame.

6. Outstanding Balances and Collection

- The Patient agrees to promptly pay any outstanding balance on their account. If payment is not made within the agreed-upon terms, the Clinic reserves the right to refer the account to a collection agency. The Patient will be responsible for any additional fees incurred due to collections, including but not limited to collection agency fees, attorney fees, and court costs.

7. Agreement to Pay

- The Patient agrees to pay all charges in full or according to the terms outlined by the Clinic. If any dispute arises regarding the charges, the Patient agrees to communicate directly with the Clinic to resolve the issue.

8. Consent to Treatment and Financial Responsibility

By signing this agreement, the Patient consents to the treatment provided by the Clinic and acknowledges responsibility for payment as outlined in this Agreement.

Signature of Patient or Responsible Party

Signature: _____
Date: _____

Patient's Information
Name: _____
Date of Birth: _____

If signing on behalf of the Patient:
Print Name: _____
Relationship to Patient: _____