VALDOSTA
Gastroenterology Associates
and
Endoscopy Center

FINANCIAL DISCLOSURE STATEMENT

Date _____

Patient Name _____ Date of Birth _____
(please print)

Thank you for choosing Valdosta Gastroenterology Associates and Valdosta Endoscopy Center, LLC (VGA/VEC). Please read and sign this Financial Disclosure Statement prior to your appointment. Patients who do not pay in full at the time of service must complete the required information and insurance forms before service will be rendered. A copy will be made of your insurance card **each time** you visit our facility to assure we have the most recent information. If proof of insurance is not provided, your appointment will be handled as self-pay and $150/new patient, $100/return patient will be collected prior to being seen.

You can expect to receive the following bills as a result of your visit:

- Physician Fee: Fee to be paid to the physician for performing the service. This bill will be from VGA.
- Facility Fee: Fees for procedures performed in our ambulatory surgery center or hospital. This bill will be from VEC or a hospital.
- Lab Fee: If a lab test is ordered or biopsies taken, a second bill will come from a lab or radiologist.

Some insurance companies require precertification for our services. We will make every effort to verify your benefits and obtain any necessary precertification prior to your appointment. This is not a guarantee of payment.

Your insurance company will send you a Explanation of Benefits that will explain how your bill was paid by them and any amount for which you may be responsible. It is your responsibility to understand your insurance benefits.

Some insurance plans require you to pay different out-of-pocket amounts based on the location where the service is performed. Deductibles, co-insurance and co-payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. We will submit primary, secondary, and tertiary claims on your behalf as long as the information needed to process the claim is obtained and verified before your visit. If this information is obtained after your visit, the patient or guarantor is responsible for the balance.

We accept cash, checks, and major credit cards. VGA/VEC will collect co-payments at the time of service. Additional payment may be required based on your insurance plan. If you have a balance due your payment will be applied to the oldest balance first. In the event your account has a credit for one of our affiliates (VGA or VEC), and a deficit for another, we reserve the right to transfer credits to any outstanding balances prior to issuing a refund.

If you are unable to keep your appointment, please reschedule at least 48 hours in advance. A missed office appointment will result in a $25 fee added to your account. A missed procedure appointment will result in a $100 fee added to your account.

It is understood that returned checks made payable to this office for insufficient funds, stop payments, or other reasons for non-payment will be assessed a $25 service charge for which you will be held responsible.

In the event that your account is placed with a collection agency, a charge that is equal to 30% of your balance will be added to your account to cover collection costs.

PATIENTS REASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand the billing practices of VGA/VEC and that I may receive multiple bills related to my service as explained above. I authorize payment of medical benefits to VGA/VEC and authorize them to release any medical information necessary to process claims. I give VGA/VEC permission to apply payments received to balances due and understand that payments will be applied to the oldest balance first. I understand that I am financially responsible for any co-payments, deductibles, co-insurance and non-covered services as outlined by my health plan.

_____ Date _____

* Patient/Authorized Representative Signature * If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

_____ Date _____

Witness

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT

I, _____, hereby acknowledge that VGA/VEC, LLC has given me the opportunity to read a detailed notice of their Privacy Practices.

_____ Date_____
Patient/Authorized Representative Signature * if patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

If not signed, please provide a reason why the acknowledgement was not obtained.

_____

_____ Date _____
Witness/Staff Signature

CONSENT TO RELEASE INFORMATION

In the event I cannot be reached, I, _____, give permission for a representative from VGA/VEC, LLC to speak with family member(s) or companion(s) listed below regarding care or test results.

Name _____ Phone _____
Relationship _____

Name _____ Phone _____
Relationship _____

Is it OK to leave results or information on your voicemail? ☐ Yes ☐ No

_____ Date _____
Patient/Authorized Representative Signature *If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

CONSENT TO CORRESPOND ELECTRONICALLY

While VGA/VEC takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with a VGA/VEC physician regarding my medical care, the VGA/VEC physician and/or his/her representative has my permission to correspond via that email address.

I give permission for a VGA/VEC physician or clinical staff member to email me at

_____ @ _____ regarding my medical care.

_____ Date _____
Patient/Authorized Representative Signature *If patient is a minor (under the age of 18), the form must be signed by a parent or legal guardian.