

**DA VINCI SURGICAL HEALTH / GASTRO-INTESTINAL CONSULTANTS**

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize direct payment of surgical / medical benefits to Gastro-Intestinal Consultants of central FL, LLC, for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by insurance. I authorize Gastro-Intestinal Consultants of central FL, LLC, to release any medical or incidental information that may be necessary for either medical care or processing applications for financial benefit.

**AUTHORIZATION TO RELEASE INFORMATION**

I \_\_\_\_\_, given permission for Gastro-Intestinal Consultants of central FL, LLC, to release and obtain my medical records from DR. \_\_\_\_\_  
Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ I also understand that this consent can be cancelled at any time with written cancellation in the future will have no effect on any records that may have already been released prior to the recipient of the written cancellations. This authorization will remain in effect if I am the patient of Gastro-Intestinal Consultants of central FL, LLC.

**ACKNOWLEDGEMENT FORM**

Our notice of privacy practices information about how we may use, and release protected health information about you. You have the right to review our notice before signing this form. As provided in our notice, you may obtain a revised copy by writing about our practice or requesting a copy from the front desk staff. You have the right to request that we restrict how protected health information about you is used or released from treatment, payment, or health care operation. We are not required to agree to these restrictions, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about your treatment, payment and health care operation as described above. You may have the right to revoke this consent in writing, except where we have already made releases in reliance on your prior consent.

(Print) Last Name \_\_\_\_\_ (Print) First Name \_\_\_\_\_

Patient signature \_\_\_\_\_ Date: \_\_\_\_\_

Please include any family or friends we release your health information

Name \_\_\_\_\_ Ph \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Ph \_\_\_\_\_ Relationship \_\_\_\_\_

\*\*\*\*\* OFFICE USE ONLY \*\*\*\*\*

Date: \_\_\_\_\_

Employee Name \_\_\_\_\_ Signature \_\_\_\_\_

Please fax patient records as soon as possible to Fax (352) 742-1124 (medical records)

NO SHOW NOTICE / PROCEDURES CANCELLATIONS

Your procedure is a time that has been set aside exclusively for you with Dr. Lal Nagabhairu M.D / Dr. Shams Tabrez M.D your gastroenterologist.

We understand that your time is very valuable to you, and to respect your time and our other patients, we required two business days' notice to change or cancel your appointment or procedures.

We understand we all have busy lives and things can come up last minute from time to time. However, last minute cancellations and no shows are subject a **\$50.00** cancellation fee.

Thank you, for your cooperation

Gastrointestinal Consultants of Central FL, LLC

Dr. Lal Nagabhairu M.D

Dr. Shams Tabrez M.D

Pt signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## UNDERSTANDING COLONOSCOPY & EGD BILLING

Subject to four bills for one procedure they will be as follows:

- Facility charge (The place where your procedure is scheduled).
- Physician charge for the procedure itself
- Anesthesia charge
- Lab charge (For testing or if biopsies are taken)

Gastro Intestinal Consultants of Central FL and Premier Surgical Center make every effort to call your insurance company to verify coverage for your procedure.

**THIS IS NO GUARANTEE OF PAYMENT FROM YOUR INSURANCE COMPANY. IT IS THE PATIENT'S RESPONSIBILITY** to know the coverage of your policy. If you have questions regarding the coverage of your procedure, you need to contact your insurance company directly. **Gastro Intestinal consultants of central FL and Premier Surgical Center** can only estimate charges incurred for our Physician's and anesthesia services. If you have questions regarding any of the above-mentioned charges, please contact your insurance company or our billing department (352) 383 - 7703.

### **SCREENING COLONOSCOPY**

A screening colonoscopy is usually covered 100% under your insurance preventative benefit. **HOWEVER**, while the doctor is performing your screening, he may find a polyp. He may at that time remove the polyp and have it sent for biopsy. While the main colonoscopy code should still be covered by your preventative benefit, there may be a portion that the patient may owe for that polyp or biopsy.

### **EGD (Upper Endoscopy)**

An EGD is not covered 100%. Depending on your insurance plan you will be responsible for your deductible co-pay or coinsurance. The portion you are responsible for will be collected at the time of your procedure. Any money collected upfront is only the surgical facility. You will still receive your bill for the anesthesia and doctor.

Pt signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_.

## FINANCIAL POLICIES

1. Please bring your insurance card to the office EVERY visit
2. Your co-pay is due at the time of service before every appointment.

### 3. How may I pay?

We accept payment by cash, credit card & care credit. If you have no insurance or if we are not able to verify insurance eligibility, we ask that you pay for the visit at the time of service.

### 4. Do I need a referral or pre- authorization?

If your insurance plan requires a referral and authorization from your primary care physician form your insurance, you need to contact your primary care physician or insurance company to be sure it has been obtained. **IF WE HAVE NOT RECEIVED AN AUTHORIZATION PRIOR TO YOUR ARRIVAL AT THE OFFICE YOUR APPOINTMENT WILL BE RECHEDULED.**

### 5. What is my financial responsibility for services?

It is your responsibility to verify that physicians or facility in which you are seeking treatment are an authorized provider under your insurance plan. If we do not have verification that you are covered by an insurance plan, you will expect to pay the charges in full at the time of the visit.

### 6. What if my visit is due to an accident or involves an Attorney?

You will need to pay at the time services are rendered. Any information you have on your case including:

- Accident date, injury, past procedures (etc.) you must bring in with you and tell the front office staff when you check in.
- Your Attorney may provide you with a letter of protection (LOP), if for some reason we do not accept you LOP, then you will be responsible for payment in full at the time of service.
- If your LOP is accepted, your Attorney must provide a check the day services are rendered.

### 7. Balance and payment plans

It is your policies the we send out 3 patient billing statements for balance due. After which we Will roll your account over to an outside collection agency. To avoid this, please contact our Billing department. Anything that your insurance does not pay after 30 DAYS becomes your Responsibility. We realized medical bills involving health insurance can be very complicated. Our goal is you help you become aware of your responsibilities as an insured member. Our billing department can be reached at (352) 383 -7703 if you ever have any question or concerns over any of the above.

I have read, understand, and agree to the above Financial policy. I understand that charges not covered by my insurance company as well as applicable co-pay, deductibles and any charges older than 30 days from the date of service.

I authorize Gastro Intestinal Consultants or Central FL to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Gastro Intestinal Consultants of Central FL

Pt signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_.