



## OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please let us know if you have any questions regarding our fees, financial policy or your financial responsibility.

- ❖ All patients must fill out all patient information forms prior to your scheduled appointment. All returning patients will be asked to verify and update the information we have on file as well.
- ❖ You must provide your insurance information for your file and copies of your card(s) will be made upon your arrival.
- ❖ **CO-PAYMENTS & CO-INSURANCE** – By law we **MUST** collect your insurance carrier's designated co-payment at the time services are rendered. You must be prepared to pay at each visit. If your plan charges a co-insurance in addition to a co-payment, we will bill you for that portion after the insurance company processes the claim.
- ❖ **NON-CO-PAYMENT PLANS** – If your plan does not require a co-payment and we participate, we will accept the designated fee. You are responsible for any deductible and co-insurance balances that your plan indicates on their explanation of benefits.
- ❖ **REFERRALS** – If your plan requires a referral from your primary care physician it is **YOUR RESPONSIBILITY** to obtain the referral, or the referral # prior to your appointment and have it with you for your visit. **YOU WILL NOT BE SEEN WITHOUT IT.**
- ❖ **NON-PLAN & SELF PAY PATIENTS** - Payment is due at the time services are rendered **UNLESS** other financial arrangements have been made prior to your visit. Our office will file a claim to your insurance carrier on your behalf and they will reimburse you directly, should you have out of network benefits. For self pay patients - our office will provide you with an itemized receipt for your records.
- ❖ **SCREENING COLONOSCOPIES** – **ALL** patients scheduled for a “screening” colonoscopy must use the Screening Colonoscopy Patient Information Worksheet enclosed to inquire on how, and if you will be covered by your insurance company to have this procedure. If your colonoscopy has been scheduled as a “screening” (meaning you have no symptoms or complications) and the physician finds a polyp, tissue that has to be removed or biopsied, or any other medical condition, this Colonoscopy is **NO LONGER A SCREENING PROCEDURE. Your insurance benefits will be different at this point and you need to verify your benefits prior to the procedure - at least 10 DAYS in advance.** **MEDICARE PATIENTS ARE ENCOURAGED TO CHECK THEIR RECORDS AS TO WHEN THEIR LAST “SCREENING” COLONOSCOPY WAS PERFORMED** – Medicare only covers screening colonoscopies every 10 years unless you are “high risk” (e.g. polyps, personal history of GI malignancy or First Degree Family History of GI malignancy – First Degree Family members include: Mother, Father & Siblings **ONLY!**) The CPT or Procedure code(s) are **G0121** and **G0105**.



DAVID D. MARKOWITZ, M. D.

OUR FINANCIAL POLICY (cont'd)

- ❖ **OTHER GI PROCEDURES** – All patients scheduled for any other procedure must use the GI Pre-authorization Checklist Form to inquire on how, and if you will be covered by your insurance company for this procedure. **In particular, BRAVO Capsule Studies are NOT covered by SOME insurance carriers** and we strongly advise checking this benefit in advance. The CPT or Procedure code is 91035.
  
- ❖ **ADVANCED BENEFICIARY NOTICE (ABN)** – Our office may require certain patients to sign a “waiver for non-coverage” prior to your scheduled procedure. This form simply states the procedure information and fee’s associated with your appointment, which your insurance company may not pay for. It protects you from any misunderstanding of fee’s prior to your procedure, as well as helps you understand what you may be billed for from your insurance carrier, or our office after the billing process is completed. In turn, it protects the physician and guarantees reimbursement.

You are responsible for timely payment of your account. We accept cash, checks, credit and debit card payments. A service charge will be assessed on all NSF checks.

I have read the above information and agree with the terms.

Signature\_\_\_\_\_ Date\_\_\_\_\_

Thank you for your attention and cooperation.

*Dr. Markowitz and Staff*