Hudson Valley Gastroenterology PC

PATIENT FINANCIAL AGREEMENT

Patient Name: ____________________________ Patient DOB: _________________________

General

I voluntarily consent to evaluation, treatment and/or procedures to be performed by or under the direction of Hudson Valley Gastroenterology, PC ("Practice"). I have been advised and understand that services may be provided by several different providers who may bill me separately. For instance, I may receive separate bills for anesthesia, pathology, laboratory, CDx Diagnostics for WATS Biopsy, and/or office-based facility charges. I understand that aside from standard deductibles, co-pays and/or co- insurance in compliance with the Federal and NYS No Surprises Act these ancillary providers will not likely balance bill for any payment amounts not covered.

Health Insurance

I understand that the Practice participates as an in-network provider with most health insurance plans including, but not limited to, Medicare, Medicaid, [fill in additional plans with which you participate] I understand that this is not a complete list, and that I will verify participation at the time I schedule my appointment. By my signature below, I authorize the Practice to release my health care information to my health insurance carrier(s) to determine if the services I receive are covered under my plan and to process payment for the services provided. By signing below, I assign all benefits to be paid for the services provided by or under the direction of the Practice to the providers that rendered the service(s) to me. The Practice will accept payment from my health insurance plan(s) as payment in full under the terms of their participating provider agreement. I further understand that it is my responsibility to notify the Practice of any changes to my health insurance coverage status, benefits, or if I join another plan that would relinquish or change my Medicare, Medicaid or other healthcare coverage.

Patient Financial Responsibility Under Insurance

I understand that insurance is a means of reimbursement and not a substitution for payment. I agree to pay all applicable co-payments, coinsurance, deductibles, out-of-pocket expenses due under the terms of my health plan, and any collection costs incurred by the Practice for amounts owed by me. I agree that payment due from me will be paid at the time services are provided. I understand that payment may be made by cash, check, debit card, or credit card.

NOTE: Medical bills paid by credit card are no longer considered medical debt. By paying with a credit card, I understand that I am foregoing certain federal and state protections around medical debt. By paying with a credit card, I acknowledge that I am foregoing the following protections: (i) prohibitions on wage garnishment and property liens; (ii) prohibition against reporting medical debt to credit bureaus; and (iii) limitations on interest rates.

Patient Financial Responsibility for Non-Covered Services

I also understand that not all services necessary for my overall wellness or otherwise requested by me and provided by the Practice are covered by my insurance for a variety of reasons. I understand that my insurance may deny or delay payment or pay only a part of what is due. For instance, the Practice may not participate with my insurance plan, the services may be deemed non-covered services, or I failed to comply with my insurance plan requirements. I understand and agree that I will receive an Advanced Beneficiary Notice (ABN) any time it is expected that my health plan will not cover a service. I understand and agree I am personally responsible for paying all the fees associated with any and all non- covered, unreimbursed, under-reimbursed and/or denied services, tests, treatment, procedures or medication.

Good Faith Estimate

I acknowledge that if any of the services to be provided by or under the direction of the Practice are non-covered services under my health insurance plan, or if I do not have health insurance, I will be deemed a self-pay patient and I have a right to request a good-faith estimate of the cost of the services and the Practice will provide me with such estimate.

No Show and Cancellation Policy

I agree that I must arrive at my scheduled appointment on time so that the Practice is able to dedicate the time necessary to provide the best possible care and treatment to me and other patients. I agree that if I have to change or cancel an appointment, I will notify the Practice 48 hours prior to my scheduled office visit and 72 hours prior to any scheduled procedure. All notifications must be by telephone (845-331-8222) and require that you speak to an office staff member. Voice mail messages or messages left with the call center are not acceptable forms of notification. If I fail to cancel or reschedule a scheduled appointment, I will be responsible for paying an administrative fee of $100.00 for office visits and $150.00 for procedures and will not be able to schedule another appointment until the administrative fee is paid. I understand and agree that repeated cancellations or no-shows may result in discharge from the Practice.

By signing electronically in the office at the time of service, I acknowledge that I have been provided with a copy of this document in advance, read this document in its entirety or had it read to me, fully understand and agree to its terms, and all of my questions have been answered to my satisfaction.

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Patient Signature (electronically) Date