PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

The Center was established to meet the special needs of patients with gastrointestinal complaints or diseases. It is an "Ambulatory Surgery Center" specially designed for the practice of Gastroenterology -- no other medical procedures are performed here. The mission of the Center is to provide quality care in a specialized outpatient setting. Each patient will have our utmost careful and personalized attention.

Please be aware that some of the physicians performing procedures here have a direct financial ownership interest in this center.

In order to ensure that our patients understand their financial responsibility and our payment policies, we ask that you take a minute to read the following and discuss any questions you may have with our billing representative.

1. The fee that BCDH charges for its services covers the non-professional component of the procedure, also known as the "technical" or "facility" fee. The technical fee includes the costs of operating this facility such as the costs for equipment, staff, rent, supplies, etc. There will also be separate bills from the physician's office and the anesthesia service for their respective professional services. As well, if a specimen is extracted during the procedure, the insurance company will dictate to which laboratory it can be sent for processing. The Center sends its specimens to the physicians' office lab or to the hospital depending on insurance requirements. Consequently, either the physicians' office or the hospital will bill the insurance company and/or patient for the pathology service. The Center does not employ or control the anesthesiologists, laboratory or physicians. The facility, anesthesiologist, laboratory and physicians' professional office are all separate legal entities providing separate and distinct services.
2. As a courtesy, insurance claims will be submitted on your behalf to the insurance company you specify during the registration process. We must have the complete name and address of the insurance company, as well as the subscriber's name, social security number and birth date. You should also present the group number for your insurance plan and any other required pre-authorization for the procedure.
3. We expect all known co-payments and deductibles, except for those due under Medicare/Medicaid or other federal healthcare programs, to be paid at the time of service or as required by the contract between the patient, the insurer and the Center. We reserve the right to collect copays, deductibles and coinsurance upon notification by the insurer.
4. Some insurers require pre-certification preauthorization or a written referral. It is the patient's responsibility to understand the insurance plan requirements and to ensure that the proper authorization is obtained at least three days prior to the date of service. Failure to do so may result in denial of the claim by the insurer. We cannot accept responsibility for a disputed claim.
5. If you are having financial difficulty or have any questions, please contact our Billing Office to discuss your account. Non-payment of accounts will result in referral to an outside collection agency that could impact the patient's credit record. Legal fees and collection costs incurred to collect outstanding accounts will be the patient's responsibility.

I have read the above and understand and agree to the terms set forth in this Acknowledgement of Financial Responsibility. I understand that regardless of any insurance coverage I may have, I am ultimately responsible for payment of my account with the Center.

Patient's Signature: X _____ **Date:** _____

Center Representative: _____ **Date:** _____

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