T. J. Khan, MD, FACG **J. J. Khan, MD**
8421 Pointe Loop Drive, Venice, FL 34293 * Phone 941-412-9787 * Fax 941-480-0388
www.surgeryvenice.com

FINANCIAL AND INSURANCE POLICY

INSURANCE PLANS: I understand that it is my responsibility to confirm with my insurance company that the physician is currently under contract with my plan or be willing to be seen at "out of network" benefits. Any questions about medical, preventive care, labs and X-ray coverage should be directed to my insurance carrier prior to my visits. **I agree to be responsible for all co-pays, deductibles, and non-covered services determined by my insurance plan. I also verify that I am currently covered and up to date with my premiums with my insurance company. Please note that Gastroenterology Associates and Center of Surgical Excellence are separate entities and will bill separately.**

SELF PAY: If I do not have proof of insurance coverage at the time services are rendered, I understand that payment is due at the time of service.

PAYMENTS: I will promptly pay all amounts that have been determined my responsibility by my insurance carrier upon receipt of my statement. I understand that my health insurance contract is between my insurance company and myself. If my insurance does not pay for the services rendered by the practice doctors within 45 days, the practice may look to me for payment. The practice agrees to refund any overpayment that I have made on my account in the event that my insurance eventually pays. Any balance remaining after my health insurance pays, denies, or deems non-covered under my plan will be my responsibility. **If I have questions related to payments or insurance payments, I will address them with Gastroenterology Associates and/or Center of Surgical Excellence's billing representative.**

CHECK IN: Co-pays and past due balances are due at the time of check-in. Please come prepared to pay. If you do not have your co-pay or have not come prepared to pay past due balances, your appointment may be rescheduled for a later time so that you may meet your obligation. Please also bring your current insurance card with you at each visit. **Pursuant with insurance guidelines, patients will be required to update their information yearly/monthly as required.**

APPOINTMENT NO SHOWS: We expect patients to give at least a 24 hour notice if they are not going to keep their appointment. When you make a commitment to an appointment, other patients loose the opportunity of scheduling that date or time. **Three or more No Shows may result in transfer of care to another practice.**

SERVICE FEES: Your account will be charged $35.00 for NSF/returned checks. Patient due balances of **90 days** or more (unless previous financial arrangements have been made) will be considered delinquent, and given a final notice. You will then become responsible for paying out-of-pocket at the time of service and for submitting claims to your own insurance company. **You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.**

If duplicate requests for patient forms become burdensome, we may charge $5 per form to cover the additional staff time required. For copies of medical records that are not associated with continuation of medical care, there will be a fee assessed of $1 per page for the first 25 pages and then $0.25 for each additional page.

I have read, understand and agree to the above financial and office policy. I understand that non-compliance with this policy may result in transfer of care to another practice.

PATIENT SIGNATURE____DATE ___________

PRINT NAME____DOB:____________