Fatema S. Uddin, MD, PLLC
Gastroenterology

FINANCIAL POLICY

Patient Name: ____ DOB: ____________________
(please print)
Date: _______________________

Thank you for choosing Fatema S. Uddin, MD, PLLC for your gastrointestinal care. We are committed to the highest quality of care. As part of the provider/patient relationship, we believe that it is important for you to understand our Financial Policy regarding payment for services. We ask that you review and sign this policy prior to any treatment.

REGARDING INSURANCE COVERAGE

We serve as a participating provider with a variety of insurance plans. All fees for co-pays, deductibles and non-covered services will be collected at the time of the visit. We accept cash, checks, credit cards, and money orders.

The balance of all visits/treatments is your responsibility whether your insurance company pays or not. In order to bill your insurance, it is necessary for you to bring in all insurance information. If you do not provide us with the correct insurance information at the time of service and this results in non-payment by your insurance company, then you will be responsible for the payment of your visit. If your insurance coverage is with an HMO or other Managed Care Program, we will bill them for you only if you present an authorization for services from them. **It is the patient's responsibility to obtain a proper referral for the visit.** Your referral must be in our office at the time of the visit. If you do not have an authorization for each visit and/or treatment, the responsibility for payment will be yours and must be paid at the time of service. If you wish to use your health savings account/FLEX account for your copayment/coinsurance, then you will need to bring the appropriate payment modality to your visit. We will need to collect this at the time of the visit. There will be a $25.00 fee for completing any outside paperwork.

Returned Check Fee: There is a $30.00 returned check fee. The original amount of the check plus the returned check fee must be paid within 10 days of when the check was returned. If we do not receive the payment as stated, we will submit the returned check to the District Attorney's office for legal action.

We require a 24-hour notice for all cancellations and reschedules for appointments and procedures. If you fail to provide the proper notice, there will be a $75.00 fee for cancellations of office appointments and a $150.00 fee for procedures.

Requests for medical records require a release of medical records form signed by the patient. A base fee of $50.00 will be charged when copies of medical records are requested by patients.

All fees that are due must be paid prior to scheduling a subsequent appointment or procedure.

I have read the Financial Policy (above). I understand and agree to this Financial Policy.

Signature of Patient/Responsible Party

X____ **Date** __________________________

Signature of Co-Responsible Party

X____ **Date**__________________________