DIGESTIVE DISEASE SPECIALISTS, INC.
. Integris DDSI Endoscopy Centers, LLC, Digestive Disease Pathology, LLC

PATIENT INSURANCE and FINANCIAL POLICY

Thank you for choosing us for your health care. Our AECs and offices are privately owned by the physicians of Digestive Disease Specialists, Inc. (DDSI). The information below outlines our financial policies and expectations in regard to payment for services provided to you by DDSI. If you have any questions about these policies, please contact Business Services at 405-767-6630.

IF YOU HAVE INSURANCE: Please bring/present all health insurance cards or policy information with you at the time of service. If this information is not provided, your account will be set up as uninsured and payment in full will be expected at the time of service.

- It is your responsibility to check with your insurance plan regarding any co-payment, deductible or co-insurance you might owe at the time of service. All non-covered services and denials may be the responsibility of the patient if applicable.
- Insurance claims are filed as a courtesy. It is your responsibility to see that the claims are paid.
- Our insurance verification team will check benefits, co-pays and deductibles for any procedure scheduled at our endoscopy centers. You should receive a telephone call from the verification team a few days prior to your procedure (time permitting).
- We cannot guarantee payment by your insurance company and all quotes given are estimates. Co-pays and deductibles could change once the claim is processed by your insurance company, depending on your plan's details and the physician's final diagnosis.

IF YOU DO NOT HAVE INSURANCE: Payment in full is expected prior to services rendered**. Exception**: Extenuating circumstances may require that a payment plan be set prior to services rendered. .

ALL PATIENTS (please initial each section)

- ___ **FORMS OF PAYMENT:** DDSI accepts checks, cash, Visa, MasterCard, Discover, American Express, Debit Cards, Health Saving and Online Bill pay by accessing our website www.okddsi.net (Resource: Pay My Bill). For assistance with either, you may contact the Business Services 405-767-6630. We also offer recurring payment options and financing through Care Credit.
- ___ **RETURNED CHECKS:** A $35.00 charge will be added to your account for any check returned by your bank for any reason. This will be in addition to charges made by your bank. DDSI cooperates with the Oklahoma County District Attorney's Office to prosecute bad check writers. (Any amount less than $50 is considered a misdemeanor and amounts exceeding $50 is considered a felony)
- ___ **NO SHOW/CANCELLATION/RESCHEDULES:** We have reserved time and resources, just for you. Thank you for understanding that without sufficient time to refill your appointment, valuable medical resources are wasted, and cannot be recovered. Not providing our office with a minimum of 48 hours advanced notice of your intent to **cancel,** or **not show** for an office visit, will result in a $50.00 surcharge to your account. Not providing our office with a minimum of 72 hours advanced notice of your intent to **cancel** or **not show** for a procedure, will result in a $200.00 surcharge to your account.
- ___ **SCREENING PROCEDURES**: If you are scheduled for a procedure: the facility submits procedural documentation and charges according to Centers for Medicare and Medicaid Services guidelines and is not responsible for determining how your benefits will be paid. Please keep in mind that ALL charges may not be covered under your screening and health preventive benefits.
- ___ **WORK COMP:** We will file your work comp claim provided we have received authorization from your adjuster. NOTE: If you notify our office that your injury is work related, we will NOT file your health insurance.
- ___ **PATIENT CREDITS:** Overpayments may occasionally result in a credit balance on a patient account. DDSI issues a refund check to the patient for any credit balance in excess of $9.99 and upon the patient's request if less than $9.99. (Note: Credits created by use of a credit card will require credit applied back to that card)

For billing purposes, there could be four (4) separate service components which will be billed:

- **Professional Component**…physician's professional services that are provided during your procedure.
- **Facility Component**…facility fee for the use of the Ambulatory Endoscopy Center in which your procedure is being performed.
- **Pathology Component**….If biopsy's taken you will receive 2 bills…1 for technical component (prepping) from DDSI and 1 for professional component (reading) from Advanced Pathology Solutions
- **Anesthesia Component**….DDSI provides a higher level of sedation known as monitored anesthesia care in which we use 'Propofol'.

YOU ARE ENTERING INTO A FINANCIAL CONTRACT BETWEEN YOURSELF AND OUR COMPANY

- I understand that responsibility for payment of medical services in this office/endoscopy center for myself and my dependents is mine. Co-pays and deductibles are due and payable at the time services are rendered unless financial arrangements have been made in advance with our Business Office.
- I understand that any co-insurance and/or deductible incurred, after my insurance company processes claims for services provided, is expected within 30 days of the first statement date.
- I understand if my account is not paid in full within 30 days of my first statement and payment arrangements are not set up, collection proceedings will begin **and my account will be considered delinquent**. We utilize collection agencies for past due/unpaid accounts.
    - I understand if I have an unpaid balance at DDSI and do not make acceptable payment arrangements to bring my account current, my account will be placed with an external collection agency. I further understand I will reimburse DDSI the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable attorney fees, that DDSI incurs in such collection efforts. This will be assessed to my account and included in the balance due. Finally, I understand this will result in endangering my credit rating on a local and/or national level by being reported to all three-credit bureau's (Equifax, TransUnion and Experian).
    - I authorize DDSI to contact me via current and any future cellular phone number(s), email address(es), or wireless device(s) regarding my delinquent account, any debt I owe to DDSI or to receive general information from DDSI. I authorize DDSI and its agents, representatives, and attorney's (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages, and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account financial obligation which is past due.
- DDSI may disclose any or all of the patient's information for insurance claim purposes. If some other party is paying the patient's bill or by any contract may be expected to pay the bill, then DDSI may disclose any or all of the patient's information to that party to verify charges. DDSI may disclose any or all of the patient's information to all health care providers who have a legitimate need for such information which indicates the presence of a communicable or venereal disease (such as Hepatitis, Syphilis, gonorrhea, HIV also known as AIDS) and/or presence of alcoholism, drug abuse and mental health problems. I authorize release of all information from DDSI for these purposes.

I have read, understand and agree to the provisions of this Insurance and Financial Policy Form (refusal to sign will result in patient not seen).

_____ _____

Signature of Patient or Responsible Party Date

Photostat of the above is as valid as the original. **1/3/23**