Colorado Pediatric Gastroenterology
1601 E. 19th Avenue, Suite 3500
Denver, CO 80218
303.830.9190

Financial Policies and Information

Our commitment is to provide the very best care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's health care and financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, or your insurance coverage and your responsibilities.

Professional fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's training and education, supplies, and support costs associated with providing and coordinating your care.

Patient Payments/Balances: Co-payment, deductibles, services not covered by your insurance plan or outstanding balances are due at the time of your appointment. **All account balances must be paid within 90 days of receiving your first statement.** Payment may be made by: cash, check, Visa or MasterCard. Nonpayment may result in your account being turned over to a collection agency.

Patients having medical procedures: If your deductible and co-insurance amounts have not been met, we will collect $250.00 from you at least three (3) business days prior to your procedure. Once we receive the Explanation of Benefits from your insurance company, and if a refund is due to you, we will provide a refund payment to you within ten (10) business days.

Insurance Payments: We participate in assignment of payment with **specific** insurance plans in the area. When the correct insurance information is provided, we will submit your claims as a courtesy to you, our patient. Your insurance coverage is a contract between you and your insurance plan. You are responsible for unpaid balances left on your account regardless of the amount your insurance coverage.

Self-Pay: Patients who are not billing a third party or health insurance are required to pay at the time of service for all office services at the time of service and will receive a 25% discount off our fee schedule. All procedures requiring services at a facility (hospital or surgery center) are pre-paid to the office within three (3) business days and will receive a 25% discount. If payment is not received within the specified time period, the procedure will need to be rescheduled.

Missed appointments: Please understand your appointment is time that has been reserved for your needs and that your lack of attendance at that visit prevents others from receiving care at that particular time. To assist patients with access to our physicians, we will charge a fee of $50.00 for any office appointment not canceled 24 hours in advance.

Medical Forms: The completion of disability forms, FMLA, attending physician statements and other supplemental insurance/employer forms require additional physician and staff time. A fee of $25.00 will be charged for all forms to be completed.

Collection Agencies: If it becomes necessary to place your account with a third party collection agency due to your non- payment, the account of the person responsible will be turned over to collections, and the patient will be dismissed from our practice.

Bounced Checks: A $35.00 charge will be applied for each check returned by the bank.

Your signature on this page constitutes an agreement to this policy.

Patient/Responsible Party Signature_____ **Date** _____

Patient Name (Print) _____