

PROFESSIONAL SERVICE AGREEMENT

Thank you for choosing our practice as your health care provider. We are committed to your medical treatment being successful. It is our doctor's belief that the effectiveness of our practice and staff depends on the efforts of you, our patient, as well as those of our physicians and staff.

MISSED APPOINTMENTS AND CANCELLATIONS

It is your responsibility to give the office 48 hour advanced notice of any appointment cancellation. If you fail to notify the office, a \$25.00 (twenty-five dollar) charge (not reimbursable by insurance carrier) will be charged to your account for any missed office appointment. If you fail to cancel an endoscopy appointment, a \$50.00 (fifty dollar) charge (not reimbursable by insurance carrier) will be charged to your account. If you show a pattern of missed appointments without cancellation, then you may be instructed to seek your healthcare elsewhere.

KNOWING YOUR PLAN REQUIREMENTS

Patients should know the requirements of their individual insurance plans. This may mean that you need to contact your insurance carrier to check on their requirements and/or plan limitations.

You are required to know which hospitals or ambulatory surgery centers are covered by your plan prior to your initial visit with our physician so scheduling may be done at the correct facility. If precertification is required for a procedure we are performing, it is your responsibility to inform our office that precertification needs to be obtained for the procedure. Our staff will then contact your carrier to obtain the precertification required.

Your insurance policy is a contract between you and your carrier. We **cannot** guarantee payment of your claims and our office will **not** accept responsibility of negotiating claims with your insurance carrier or other facilities. You are ultimately responsible for payment of the services provided by our physician and facilities, regardless of the status of the insurance claim. If your carrier pays only a portion of your bill or rejects the claim, any contact for explanation should be made by you, the policy holder. Reduction or rejection of your claim by your carrier does not relieve you of financial obligation incurred with our office. If necessary we will lend assistance when needed to help process your rejected claims.

Screening colonoscopies are becoming a common benefit of major carriers. If you do have colon screening coverage, make sure that our staff is aware to schedule your colonoscopy as a screening, if that is appropriate, rather than a diagnostic procedure so we can bill properly to get the highest benefit possible.

MEDICARE

We do accept Medicare assignment and will bill one secondary insurance as a courtesy. You will be asked to sign an "Advanced Beneficiary Notice" for all services that Medicare may not cover, which would then be your responsibility to pay.

FINANCIAL RESPONSIBILITY

COPAYS must be paid at the time of service. This is not only our requirement, but one with your insurance plan as well. If you have insurance coverage, you must supply our staff with your accurate billing information before each visit. You are required to complete our demographic information form. You must also supply a copy of your current insurance card (or cards) before each visit. We are happy to file the claim; however, the balance is your responsibility if your plan does not pay after 30 days. Any amount not covered by your carrier is due immediately after you receive your first statement from us. If you have additional coverage, we will file a total of two insurances. If you do not have insurance coverage, payment is due in full at time of service. We accept cash, checks, money orders, Visa or MasterCard. Interest will be added to any account that is turned over to our collection agency.

PRESCRIPTION REFILLS

Please ask for prescription refills at the time of your office visit. If you need a refill between visits, simply call our prescription line. All calls regarding refills should be made at least one week before you run out of your medication. Keep in mind that some refills require prior authorization and they could take additional time to handle due to the requirements of your insurance company. When calling to request a refill, please have the patient’s name, date of birth, medication name, dosage, prescription number, pharmacy name and telephone number. When leaving a message on our prescription line, please leave a daytime phone number where we may reach you if we have any questions. Do not call after office hours or on weekends or holidays. Our answering service and on-call physicians cannot handle prescription refills after office hours without looking at your office medical record. This must be done during regular office hours.

MEDICAL RECORDS

In accordance with Ohio state law, medical record copy charges are as follows: pages 1 to 10 are @\$2.59 per page, pages 11 to 50 are \$0.53 per page, and every page after that is \$0.21. The actual cost of postage will also be included in the total cost if the records must be mailed. This charge is payable at the time you pickup your records or before they are mailed. **DISABILITY FORMS:** The office will charge \$10.00 for each disability form completed. The payment is due at the time of the request.

NSF CHECKS

The office will charge a \$35.00 NSF fee for all returned checks. Thereafter, payments will no longer be accepted by check. All future payments must be made by cash, money orders, or credit card.

Please sign below indicating that you have agreed to the above terms.

Patient’s Signature

Date

Witness