Gastroenterology Center of Northern Virginia, LTD.

Notice of Financial and Practice Policies

Referrals and Authorizations:

1. I understand that it is my responsibility to contact and secure from my insurance plan any referrals, pre-certifications or authorizations prior to receiving any non-emergency medical services from Gastroenterology Center of Northern Virginia (hereafter referred to as "GCOFNOVA"). If a referral is required and I do not bring it with me, my appointment may need to be rescheduled. If a referral is required and I do not provide one, I accept full responsibility of all charges and fees billed by GCOFNOVA.

Financial Agreement:

1. GCOFNOVA will file for insurance benefits and accept payments per contractual agreements with practicing insurance companies. Any questions or dispute concerning insurance coverage or payment of benefits is a matter between the subscriber/policy holder and the insurance company. Any assistance granted GCOFNOVA is given strictly as a courtesy.
2. I understand that I will be billed separately for "non-covered" or "incidental" services related to patient care, including but not limited to: telephone and/or email consultations, emergency prescription refills or other convenience-oriented care rendered.
3. I understand there will be a charge for medical records or any medical forms which need to be filled out by the physician.
4. I agree to pay a $50.00 fee for missed appointments not cancelled twenty-four (24) hours prior to the scheduled appointment and $300.00 fee for any procedure not cancelled five (5) business days prior to the scheduled procedure.
5. Should any balances arise due to insurance co-payments, co-insurance, deductibles, insurance denials, termination of coverage, non-addition of a dependent to insurance plan, non-payments at time of services and/or any other reason, I understand that I will be billed for these costs and agree to pay all charges within thirty (30) days of billing date.
6. If the balance is not paid within sixty (60) days of the billing date, or if agreed upon payment arrangements on my accounts are not made, GCOFNOVA may retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my delinquencies. I understand that I will be responsible for all the additional fees incurred from that attorney and/or collection agency.

Certification on Insurances and Billing Agency:

1. I certify that the information I have reported with regards to my insurance coverage is correct.
2. I agree to immediately inform GCOFNOVA of any changes in personal demographic information, insurance coverage and/or benefits.

Advance Directives:

1. GCOFNOVA acknowledges a patient's right to have an Advance Directive and will file any advance directives provided or brought to our attention in the patient's medical record and the record flagged accordingly.
2. I understand that it is the policy of GCOFNOVA physicians and staff that in the unlikely chance of a patient experiencing an urgent medical event while in the office or endoscopy center, that patient will be stabilized and transported to the closest hospital with a copy of the Advance Directive if made available to GCOFNOVA.

Practice Policies:

1. **TEST RESULTS** may take up to two (2) weeks. The results will be sent by letter unless there is cause for more immediate action, in which case you will be notified by phone.
2. In an effort to reduce call volume, please leave only one **PHONE MESSAGE.** Multiple phone messages only overload the phone system and will not ensure a return call any sooner. To better serve you, we ask that when leaving a message, you clearly state patient's name, spelling of last name, patient's date of birth and a phone number where you can be reached easily.
3. Any **FOLLOW-UP APPOINTMENTS** should be made while checking out. The schedule usually fills up quickly and may take up to 6-8 weeks for a return appointment.
4. In an effort to see patients on time, we request that new and follow-up patients arrive at your scheduled check-in time. If you arrive fifteen (15) minutes later than the check-in time, you may need to be rescheduled. **PLEASE COME PREPARED FOR YOUR APPOINTMENT WITH ALL RECORDS AND PAPERWORK.**

Patient Signature: _____ **Date:** _____

Print Patient Name: _____ **Date of Birth:** _____