Patient Financial Responsibility Statement

We ask that you please read and understand your financial responsibilities prior to receiving services.

Financial Information

1. I understand that I am responsible to provide Kumkum Patel MD, Inc. with current, and accurate billing/insurance information at the time of scheduling my appointment and at check-in.

2. I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of required personal information to my insurance company for insurance/medical purposes. I hereby authorize payment from my insurance company to Kumkum Patel MD, Inc.

3. I understand that Kumkum Patel MD, Inc. will verify insurance eligibility and obtain any necessary authorizations prior to initiating care and treatment. Prior authorization is not a guarantee that insurance payments will be forthcoming.

4. I understand that Kumkum Patel MD, Inc. currently accepts Medicare, Aetna PPO, Cigna PPO and Anthem Blue Cross PPO *only*. Other insurance plans provided to us will be considered “out-of-network” which could result in diminished insurance coverage towards my care and treatment and increase my responsibility for additional payment.

5. I understand that if I do not present your office with proof of current and active health insurance coverage, I will be asked for payment for all fees to be incurred at that visit prior to the commencement of services. Should I be unable to make such payment, my visit may be rescheduled to a later date.

6. I understand that Kumkum Patel MD, Inc. will ask for my credit card details to be on file and by providing it, I am authorizing it to be used for the required payments including but not limited to co-pays, out-of-network fees and outstanding balances. I can request to remove my credit card on file or request that it should not be used for payment in writing at any time.

7. I understand that I am responsible for the payment of all copays, coinsurance, and deductibles before commencement of services.

8. I understand that I will be charged $30 for any check returned by my bank.

9. I understand it is my responsibility to inform the offices of Kumkum Patel MD, Inc. should there be a change in my health insurance coverage.

No-Show & Late Cancellation Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. If it is necessary to cancel an appointment, patients are required to call or leave a message within the time frame stated below. Notifying our practice in a timely manner allows us to better utilize appointments for other patients in need of prompt medical care.

For procedures: Due to the number of resources allocated for endoscopic procedures, we require at least five (5) full business days' notice for a cancellation (or a request to reschedule) of a schedule appointment. Patients will be assessed a fee of $250 for each documented no show or ~~late~~ untimely cancellation of a scheduled procedure.

For routine office appointments: To cancel or reschedule a routine office visit, please do so at least forty-eight (48) hours prior to the scheduled appointment time. Patients will be assessed a fee of $100 for each documented no show or late cancellation of a routine office visit.

Any charge for late cancellation/no-show for appointments will be billed directly to you and not to your health insurance company. We understand that situations such as medical illness or medical emergencies may prevent you from attending your scheduled appointment or prevent you from giving the requisite notice of cancellation. As such, we will consider such unavoidable occurrences on a case-by-case basis.

By signing below, I acknowledge that I understand and agree to these terms:

_____	_____
Signature of Patient/ Authorized Representative	Date
_____	_____
Printed Name	Patient's Date of Birth