Gastro Center of Maryland
Phone 410-290-6677 Fax 410-290-6676

Financial Policy

I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay copayments, amounts applied to deductibles, and balances of bills not paid in accordance with the benefits of my current health insurance policy. Copayments are due at the time services are rendered. If I am unable to make payment in full for my medical treatment for any reason within 30 days of receipt of services, I agree to call the business office and make payment arrangements. Any balances that are 90 days past due may be sent to collections.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to Gastro Center Maryland, LLC, and Cascades / Olney / Annapolis/ PG County/Timonium Endoscopy Center, LLC, for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy.

I understand that payment is my sole responsibility, and that in the event of non-payment for whatever reason by any third party which I direct Gastro Center of Maryland, LLC, and Cascades / Olney / Annapolis/ PG County/Timonium Endoscopy Center, LLC to bill, I will pay immediately. It is further agreed that in the event I fail to pay upon demand, and should my account be referred to an outside collection agency or attorney, I accept full responsibility to pay all collection costs not to exceed 30% and interest of 1.5% per month not to exceed 18% per annum and any reasonable court costs.

You expressly consent and agree that, in order to discuss or provide services for your account(s) (the "Accounts") or to collect amounts you may owe, Gastro Center of Maryland and Cumbria Capital MSO, LLC and its officers, agents, affiliates, employees, first and third party debt collection agencies, and any affiliated or business associated service providers or vendors of any of these parties, associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You confirm that any telephone number provided is associated with you and not a third party. You expressly consent and agree that We may also utilize your information to contact you via mail, email using any email address you provide to us, text message, or prerecorded or artificial voice or voice messages, via predictive or automatic dialing methods, systems, or devices, and pre-recorded or artificial voice announcements or prompts at any telephone number associated with the Accounts, including landlines, wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

CANCELLATION AND NO SHOW POLICY

We understand that from time to time you may need to cancel an appointment for various reasons. Please observe the rules regarding cancellations stated below. We allow one missed appointment or no show without a charge.

1. For cancellations and reschedules that are non-emergencies:
    a. 24-hour notice is required for office appointments
    b. 2 business days for procedure appointments
2. Cancellations that are made without appropriate notice are subject to a patient charge of $50 clinic / $100 procedure.
3. If you are a no show for a scheduled office appointment you will be charged $50.00.
4. If you are a no show for a procedure appointment, you will be charged $200.00.

If you do not show up for an appointment and there are extenuating circumstances, please call us so we can handle the situation appropriately.

****This is not covered by your insurance plan and you will be personally responsible for the payment, prior to scheduling your next visit ****

RETURNED CHECK POLICY

A fee of $25.00 will be assessed to any patient whose check is returned due to insufficient funds.

By signing below, you acknowledge receipt of our Financial Policy.

_____	_____	_____
Patient or Legal Guardian Name	Patient or Legal Guardian Signature	Date