Peninisula Endoscopy Center
9315 Ocean Hwy.
Delmar, MD 21875
Ph: 410-896-9005 Fax: 410-896-9337

Financial Policy & Agreement

This information contains the terms and conditions by which we provide services and our requirements for payment by you or your Insurance Company. This Agreement applies to patients over the age of (18) and any other party assuming responsibility for payment of the services or consenting to the services for any other person including a minor or adult. Others acting on behalf of an incapacitated person or minor or assuming payment responsibility may be asked to provide written proof of status.

Insurance processing policy & agreement with assignment of benefits

Insurance is designed to reduce your cost not to eliminate it. With your assignment of payment of benefits from your insurance carrier with which we participate, we will bill your insurance as a courtesy to you provided that in advance of services, you provide proof of valid insurance including your insurance card, identification number, group number subject to your compliance with pre-authorization or referral that may be required by your insurance company; however, it is ultimately your responsibility to effectuate any payment from your insurer and our right to be paid in full by you or collect from you is not limited thereby.

Assignment of Benefits:

I hereby authorize direct payment to Peninsula Endoscopy Center of any insurance or other benefits otherwise payable to me or the patient.

For patients with insurance in which we participate:

1. I understand that insurance forms will be submitted by this office after the procedure is completed.
2. I agree to be responsible for and to pay for any portion of the bill services rendered not paid by my insurance company within 30 days after the date of remittance by the insurance company but in no event later than 90 days from the date of service.
3. I agree that I am ultimately responsible for coordinating payment of insurance benefits and will cooperate with this office and the insurance company to obtain payment. Insurance billing from Provider is a courtesy only. ***Initials:*** _____

For patients without insurance:

1. I understand that this Agreement applies to me and that full payment is expected at time of service unless prior arrangements have been made with the Provider's Billing Manager.
2. All accounts for services shall be subject to our written Collection Policy & Agreement. I will owe and agree to pay reasonable collection costs which will be added to the balance due by me to this office and become part of the overall balance due by me to this office.

If insurance or other third party payment is involved, I authorize release of any information by provider or its authorized agents related to my claim if payment in full is not made by me at the time of service. I agree to pay all copays and deductibles at the time of service or as otherwise agreed. I authorize and assign payment of benefits otherwise payable to me directly, to the PROVIDER and agree to pay any remaining balance. I agree that a photocopy of the Agreement shall be valid as the original. I agree as the patient and /or guarantor to be responsible for payment of any such co-pay or deductible, and /or other amounts not received by the Provider, from any third party source including my insurance company. I agree any payment received by me for the Provider's services shall be delivered to and applied to any balance due Provider on my account ***Initials:*** _____

Collection Policy & Agreement

When payment is not made as agreed, account balances inclusive of all charges and reasonable collection cost agreed to herein including but not limited to reasonable attorney's fees may be sent to outside collection firms for legal action. The patient and or/guarantor or responsible party shall be responsible for and agree to pay reasonable collection cost including but not limited to, reasonable collection agency fees, attorney's fees and court costs. Such fee represents administrative, accounting, bookkeeping, account maintenance, legal and management fees associated with delinquent accounts. In consideration of the acceptance of the patient named on this form by Provider and for services rendered or to be rendered to such patient, the undersigned promises to pay for and guarantees payment of all amounts due and any and all charges including collection costs described herein. If payments due hereunder is not made as agreed, Provider, may without notice or demand, declare the entire unpaid balance of the account including collection costs agreed to herein to be immediately due and payable. If court action is necessary to enforce payment hereunder, the venue for any such court action shall be Wicomico County, Maryland unless Provider elects otherwise. The undersigned waives any objection to venue or jurisdiction. A copy of this Agreement shall be as valid as the original.

I have read the above and agree to the stated terms and to pay, guarantee and otherwise accept financial responsibility for all amounts due arising from the services provided by this office to the patient named below as provided herein and foregoing office Financial, insurance processing, and collection policy and agreement.

Patient:_____ **Date:**_____

Witness:_____ **Date:**_____