

**DIGESTIVE CARE  
ARKANSAS SURGERY & ENDOSCOPY CENTER**

**FINANCIAL POLICY**

Dear Patient,

Thank you for choosing us as your healthcare provider. Our main concern is that you receive the proper and optimal treatment to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our account representative.

We ask that all patients read and sign our policy as a token of their acceptance as well as our patient information form prior to seeing the doctor.

**PATIENT RESPONSIBILITY, DEDUCTIBLES, CO-PAYMENTS & CO-INSURANCE ARE DUE AT THE TIME SERVICES ARE RENDERED.**

The percentage amount given the day of service is an estimate based on information received from your Insurance. Any difference once your Insurance pays will be billed to you. We accept cash, checks and for your convenience, Master Card and Visa. We will be happy to help you process your insurance claims for reimbursement.

We can accept assignment of **MOST** insurance benefits. However, you must understand and agree that: 1) your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. 2) All charges are your responsibility whether the insurance company pays or not. Not all services are covered benefits in all contracts. 3) We will file the claim with the insurance company on your behalf. ***HOWEVER, YOUR DEDUCTIBLE, CO- PAYMENTS and PERCENTAGE ARE DUE BY YOU AT THE TIME OF SERVICE.***

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**PATIENT NAME**

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**PATIENT SIGNATURE**

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**DATE**

**BILLING EXPLANATION**

**PLEASE READ THIS PAGE CAREFULLY**

Please be informed that once your procedure has been done, the patient or the patient's insurance will receive three (3) to four (4) bills.

- 1) **DIGESTIVE CARE, P.A**
  - The bill received from DIGESTIVE CARE, P.A. will be the PHYSICIAN'S FEE only. This is what the doctor charges for performing the procedure.
- 2) **ARKANSAS SURGERY & ENDOSCOPY CENTER "ASEC"**
  - The bill received from ASEC is the FACILITY CHARGE only. This is charged by the surgery center for the facility provided to the physician to perform the procedure
- 3) **ASC ANESTHESIA. PLLC**
  - The bill received from ASC ANESTHESIA will be for the ANESTHESIA SERVICES only provided at the time of the procedure
- 4) **PATERSON DIAGNOSTICS. INC**
  - The bill received from PATERSON DIAGNOSTICS will be for any pathology (biopsies) if required during the procedure.

If you have any questions or concerns, please do not hesitate to ask our account representative

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**PATIENT NAME**

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**PATIENT SIGNATURE**

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**DATE**

# Patient Account Payment & Collections Policy

At **Digestive Care / Arkansas Surgery & Endoscopy Center**, we value you as a patient. In order to continue to provide exceptional service to all our patients/customers, timely payment of your account is crucial. You have the power to avoid the following penalty by discharging your debt with our office when it is due.

If you fail to pay your account in full or if satisfactory payment arrangements are not timely made and timely payments are not made pursuant to the payment arrangement within 30 days following your default, we will refer your account to a collection agency.

In the event a collection agency is hired to collect any outstanding amount, you agree to pay a collection fee in the amount of thirty percent (30%) of the outstanding balance. You will be responsible for paying the collection fee that the collection agency charges for the collection of your debt and that collection fee of thirty percent (30%) will be added to your debt and collected by the collection agency. By signing below, you understand and agree to pay that collection fee.

Also, please understand that by signing this agreement in the space provided for you below, you also agree to be solely responsible to pay the other collection fees incurred by **Digestive Care / Arkansas Surgery & Endoscopy Center** and/or its assignee that are collection fees for court costs – such as filing fees, recording fees, service of process fees and attorney’s fees, which may be awarded by the Court, all of which are associated with the collection of your debt.

**“Should my account become overdue and subsequently transferred to a collection agency, I specifically agree to pay a collection fee of thirty (30%) to Digestive Care / Arkansas Surgery & Endoscopy Center and/or its assignee and the other collection fees outlined above in recovery associated with the collection of this debt in addition to the outstanding debt.”**

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**Patient Name**

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**Patient Signature**

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**Date**

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**Digestive Care / Arkansas Surgery & Endoscopy Center**

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**Date**