OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance Form before seeing the doctor, Copayments, coinsurance, and deductibles are due at the time of service. We only accept cash or Visa, Master Card, Discover, or American Express. We do NOT accept checks.
Should your patient portion of the account not be paid timely, the patient assumes all costs of collection, including, but not limited to court costs, interest, and legal fees we incur.

REGARDING INSURANCE

We will accept the assignment of insurance benefits; however, we do require a percentage of the bill to be paid at or before the time of service when applicable. The balance is your responsibility whether your insurance company pays. We cannot bill your insurance company unless you provide us with a complete and accurate date. Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. We will facilitate the claims process by filing for you. If your insurance company has not paid your account in full within 45 days, you will be responsible for the balance. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and other medical insurance.

Exceptions to the above policy are restricted to the plans for which Gopal Grandhige MD, LLC and Tampa Bay Reflux Institute are contracted providers (e.g. certain HMOs & PPOs). You will be responsible for all required co-payments and deductibles at the time of service. You will also be responsible for payments for procedures not covered by your insurance company, or procedures performed for pre-existing conditions if not covered by your policy. We will assist with obtaining authorizations for all procedures; however, pre-authorizations are not a guarantee of payment by your insurance company.
Your surgery may require a "surgical assistant" to be present. That surgical assistant may or may not be covered by your Insurance Company. You may receive a separate bill for the "surgical assistant" services based on your insurance coverage.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of normal office visits. Please help us serve you better by keeping the scheduled appointment.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

_____ I authorize direct payment of all benefits payable on my/the patient's behalf from any Insurance company or health plan directly to my physician(s).

_____ I understand and acknowledge that all unpaid charges remain primarily and principally my obligation and agree to remain responsible for payment of all charges not covered or otherwise paid from my insurance or health plan, which charges my physician(s) are legally entitled to bill me for.

SURGERY

Once confirmed, surgery dates and times CAN NOT be rescheduled for any reason except failure to be medically cleared. At the discretion of the surgeon, a $250.00 rescheduling fee will be applied.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy and understand and agree with this Financial Policy.

_____ _____

Signature of patient or responsible party Date

_____

Print Name of Patient or responsible party