Kenneth Hollis, M.D., FACS
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Patient Financial Policy

Our medical practice understands that the cost of healthcare is a key concern for our patients. It is essential that you assist us in your care by understanding your responsibility as it relates to our Financial Policy. If you have questions regarding our policy, a representative of our staff will be glad to assist you.

FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE BEFORE; OR AT TIME OF SERVICE.

We accept: Cash, Checks, Debit Cards, and Credit Cards. Competitive financing options are available to help cover deductibles, co-pays or any out of pocket expenses.

OFFICE CONSULTS:

All co-pays and deductibles are due at time of the office visit. Prior balances are due in full prior to any future elective or routine aftercare other than usual postoperative care. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred. Surgery quotes are estimated and due in full five business days prior to surgery.

To summarize, your financial responsibility pertains to:

- Denied and Non-covered services
- Services deemed not medically necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pending claims due to lack of patient and/or guarantor information
- Non-insurance and/or out-of-network benefits

CANCELLATION POLICY:

You may cancel once, if cancellation occurs at least two weeks prior to the surgery date (10 business days) at which time you may reschedule at no cost, otherwise there will be a $250.00 rescheduling fee. If you cancel within 10 business days of their surgery, $250.00 non–refundable reposting fee will be assessed prior to rescheduling.
If our office is forced to cancel due to abnormal lab, or other reasons, there is no rescheduling fee for doing so.
You have the right to request a copy of medical information. Your request must be either made in person or in writing to our management of this office. There is a $25.00 processing fee for all requests of medical records.

**We can deny your request if you ask us to amend information that:

1. Was not created by us
2. Is not part of the medical information kept by this office
3. Is not part of the information which you would be permitted to inspect and copy
4. is accurate and complete

COLLECTIONS

Any past due balance will be turned over to a collection agency after **60 days**.

______________________________ Signature

______________________ Date

<u>TERMINATION FOR NON-COMPLIANCE</u>

It is essential that our patients follow pre-operative and post-operative instructions carefully. This includes aftercare instructions for patients with adjustable gastric bands.
Any patient who persistently and repeatedly demonstrated non compliance with our orders and instructions will be terminated from our care.

By signing below you have agreed that you understand and comply with BayChoice financial agreement.

Patient's Name: ________________________________ Date: ____________________________

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

To effectively process patient claims for insurance reimbursement, our office must have current and accurate information. It is your responsibility to provide this information. Changes in status during the period of treatment and follow up must be brought to our attention immediately. It is important to remember the insurance payments *come to us* to cover medical expenses *incurred by you*. Whether or not insurance covers a particular service does not release your from the financial obligation.

During any operation or treatment, some services or treatments maybe necessary and may bring additional charges. Examples would be pathology/laboratory, radiology, anesthesiology, surgical assistants, surgical supplies/injections, additional indicated procedures, and consultants. Depending on the plan, sometimes these charges may be inadequately reimbursed. **<u>Should the insurer deny payment on the basis of a "non-covered service", it is still your responsibility to pay these charges.</u>**

Your signature below serves to acknowledge that you agree with the above and wish to proceed with your surgical care by Dr. Ken Hollis and his surgical assistant, Beth Kramer, RN., MSN.

___________________________________ ___________________________

Signature Date