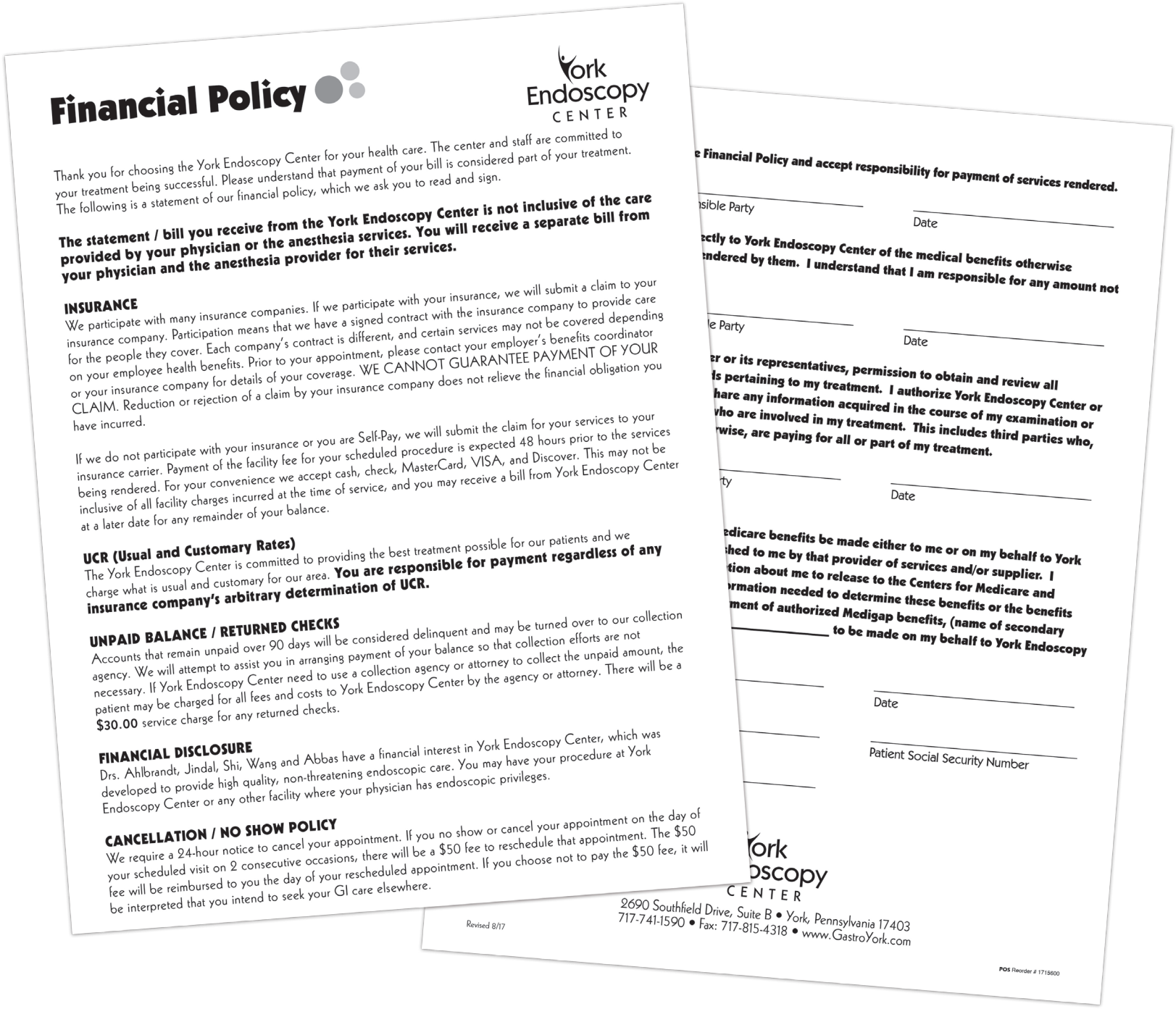

Financial Policy

York Endoscopy CENTER

Thank you for choosing the York Endoscopy Center for your health care. The center and staff are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we ask you to read and sign.

The statement / bill you receive from the York Endoscopy Center is not inclusive of the care provided by your physician or the anesthesia services. You will receive a separate bill from your physician and the anesthesia provider for their services.

INSURANCE

We participate with many insurance companies. If we participate with your insurance, we will submit a claim to your insurance company. Participation means that we have a signed contract with the insurance company to provide care for the people they cover. Each company's contract is different, and certain services may not be covered depending on your employee health benefits. Prior to your appointment, please contact your employer's benefits coordinator or your insurance company for details of your coverage. WE CANNOT GUARANTEE PAYMENT OF YOUR CLAIM. Reduction or rejection of a claim by your insurance company does not relieve the financial obligation you have incurred.

If we do not participate with your insurance or you are Self-Pay, we will submit the claim for your services to your insurance carrier. Payment of the facility fee for your scheduled procedure is expected 48 hours prior to the services being rendered. For your convenience we accept cash, check, MasterCard, VISA, and Discover. This may not be inclusive of all facility charges incurred at the time of service, and you may receive a bill from York Endoscopy Center at a later date for any remainder of your balance.

UCR (Usual and Customary Rates)

The York Endoscopy Center is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of UCR.**

UNPAID BALANCE / RETURNED CHECKS

Accounts that remain unpaid over 90 days will be considered delinquent and may be turned over to our collection agency. We will attempt to assist you in arranging payment of your balance so that collection efforts are not necessary. If York Endoscopy Center need to use a collection agency or attorney to collect the unpaid amount, the patient may be charged for all fees and costs to York Endoscopy Center by the agency or attorney. There will be a **$30.00** service charge for any returned checks.

FINANCIAL DISCLOSURE

Drs. Ahlbrandt, Jindal, Shi, Wang and Abbas have a financial interest in York Endoscopy Center, which was developed to provide high quality, non-threatening endoscopic care. You may have your procedure at York Endoscopy Center or any other facility where your physician has endoscopic privileges.

CANCELLATION / NO SHOW POLICY

We require a 24-hour notice to cancel your appointment. If you no show or cancel your appointment on the day of your scheduled visit on 2 consecutive occasions, there will be a $50 fee to reschedule that appointment. The $50 fee will be reimbursed to you the day of your rescheduled appointment. If you choose not to pay the $50 fee, it will be interpreted that you intend to seek your GI care elsewhere.

e Financial Policy and accept responsibility for payment of services rendered.

sible Party

Date

ectly to York Endoscopy Center of the medical benefits otherwise endered by them. I understand that I am responsible for any amount not

le Party

Date

er or its representatives, permission to obtain and review all ls pertaining to my treatment. I authorize York Endoscopy Center or hare any information acquired in the course of my examination or who are involved in my treatment. This includes third parties who, rwise, are paying for all or part of my treatment.

ty

Date

edicare benefits be made either to me or on my behalf to York shed to me by that provider of services and/or supplier. I tion about me to release to the Centers for Medicare and rmation needed to determine these benefits or the benefits ment of authorized Medigap benefits, (name of secondary _____ to be made on my behalf to York Endoscopy

Date

Patient Social Security Number

York oscopy CENTER

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717-741-1590 • Fax: 717-815-4318 • www.GastroYork.com

Revised 8/17

POS Reorder # 1715600