COLON RECTAL HEALTH CENTER

PATIENTS HAVE THE RESPONSIBILITY TO:

- PROVIDE INFORMATION NEEDED TO THE PROFESSIONAL STAFF IN ORDER TO CARE FOR YOU, AND TO FOLLOW INSTRUCTIONS AND GUIDELINES GIVEN BY THOSE PROVIDING HEALTH CARE SERVICES
- KEEP ALL SCHEDULED APPOINTMENTS. APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCED MAY BE CHARGED $50.
- COLONOSCOPIES AND SURGERIES REQUIRE A 48 HOUR NOTICE TO CANCEL, OTHERWISE, YOU WILL BE CHARGED A MINIMUM OF $100.
- PAY YOUR SHARE OF FEES OR CO-PAYMENTS AT THE TIME OF SERVICE
- PROVIDE INSURANCE INFORMATION THAT IS ACCURATE AND CURRENT

FINANCIAL POLICY:

Patients who have medical insurance should know that ALL services are charged directly to the patient, and that he or she is responsible for payment. We must emphasize that as medical care providers, our relationship is with you, not your insurance company, while filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date of services rendered.

All insurance forms processed by this office, prior to payment in full are assigned to this practice. Your cooperation in complying with the terms of this assignment will be appreciated. Most misunderstandings about insurance can be avoided if you understand what your insurance policies are.

LABORATORY AND OTHER TESTS DONE OUTSIDE THIS OFFICE:

You are responsible for ensuring that laboratory and other test(s) are done at a provider that is contracted with your insurance company. Consult the Member Services Department of your insurance company for assistance.

STATEMENT OF FINANCIAL RESPONSIBILITY

I have read the above and realize that all medical charges incurred by me or my dependents for services rendered by Steven M. Abbadessa, D.O. and/or his associates, are my financial responsibility.

I hereby assign payment of authorized medical and/or surgical benefits to include major medical benefits to which I am entitled, to be made on my behalf to Steven M. Abbadessa, D.O. and/or his associates for any services rendered by that physician. I authorize release of medical information to the insurance company that is needed to determine these benefits payable to the related services.

I understand that I am financially responsible for all charges whether or not paid by said insurance company. I also understand that all office co-payments are due at the time of the service. In the event that I fail to pay these charges, I will be responsible for reasonable collection costs and attorney fees associated with the cost of resolving my account. All balances over 30 days are subject to a 20% interest charge. There will be a $20.00 charge on all returned checks.

I have read this form, and as such, I realize by signing below, I understand and agree to comply with the above terms.

____ ____________________

Patient signature (or legal guardian) Date

Colon Rectal Health Center
456 North New Ballas Road, Suite 154
Creve Coeur, MO 63141
Phone: 314-966-7570 **Fax**: 314-966-7788