Central Illinois Endoscopy Center

FINANCIAL AGREEMENT Patient Name: _____

Medically Insured Patient:

As a courtesy to our patients we will bill your insurance company. Please make sure all of your information is correct and up to date with us. Your insurance cards need to be presented at the time of your visit. If we are not provided with the correct information, you will be billed and are responsible for the services rendered.

Provider Coverage:

The endoscopy center will pre-certify your procedure to ensure that our facility is covered but pre-certification is not a guaranty of payment. It is the patient's responsibility to know the specific terms and provisions of the coverage provided in the insurance policy. If your insurance denies the claim due to plan provisions or for any reason, you will be responsible for the balance.

Payment Methods:

- **We accept cash, check, MasterCard, Visa, or Discover.**
- **Self-pay procedures must be paid in full on or before the day the services are performed other than pathology which will be billed if those services are utilized.**
- **Payment Plans can be set up if necessary with no interest charged**
- **Accounts past due may be assigned to TH Professional and Medical Collections for additional collection activity.**

All no-shows and late cancellations (cancels within 24 hours) will be billed $95. To avoid this charges please notify us within 24hrs.

Please provide CIEC with a contact number you would like your messages left on. If you prefer that a message not be left on a voice mail please specify below. By signing you authorize CIEC to leave a message on the phone number provided.

HIPPA: By signing below I acknowledge that I have been given access to the center's Notice of Privacy Practice.
I hereby authorize CIEC to furnish information to the insurance carrier(s) concerning my illness and/or treatments as required for the processing of medical benefits.

Assignment and COLLECTION FEES: I hereby assign CIEC all payments for medical services rendered to my dependent(s) or myself. I understand that this authorization will remain in effect for as long as my dependent(s) or I remain a patient. I understand that I am financially responsible to CIEC for the charges not covered by this assignment. In the event that I default on payment of my charges, I understand that I am also responsible for any costs incurred in the collection process. If this account is sent to collections, the fees are typically 30 to 50% of my bill, plus court costs and attorney fees, and this charge will be added to my balance due. A photocopy of this agreement shall be as valid as the original.

Central Illinois Endoscopy strives to provide the best possible care to our patients. Your understanding of our financial procedures is important to our relationship. If you are unclear of your financial responsibilities or our Financial Policies please feel free to contact our billing department at (309) 495-1149.

I acknowledge that I have read and agree with the above Financial Policy. I recognize that I am ultimately responsible for the timely payment of my account.

Signature: _____ Date: _____

Phone number: _____ ALT Number: _____

Witness: _____ Date: _____