

# **BRYN MAWR MEDICAL SPECIALISTS ENDOSCOPY ASSOCIATES AMBULATORY SURGERY CENTER**

## **INSURANCE AND BILLING AGREEMENT**

**\*\*PLEASE SIGN, DATE AND RETURN THIS AGREEMENT TO US  
ALONG WITH YOUR PATIENT HISTORY FORM\*\***

### **INSURANCE**

Bryn Mawr Medical Specialists Endoscopy Associates (the Center) will submit medical service claims, which includes a physician procedure charge and a separate Ambulatory Surgery facility charge, on the patient's behalf to the provided insurance carrier. The Center does not assume any responsibility in regards to the contract between the patient and their insurance company. Please verify coverage with your insurance carrier, as services provided may be "non-covered" services according to your contract and our Center may be considered "out of network". Each patient will receive a bill for any non-covered services or services not paid for by their insurance company.

**It is the Center's recommendation that the patient contact their insurance company pre-procedure to verify eligibility and all potential co-pays or deductibles for outpatient procedures performed in an Ambulatory Surgery Center.**

**The Center participates with most major insurance companies.**

If a patient is not covered by an insurance plan or is covered by an insurance plan that the Center does not participate with, payment will be requested at the time of service for all surgical procedures and related costs. A payment plan can be established with a patient if the patient is unable to pay the entire bill in full on the day of the surgery; however, a payment of 25% of the anticipated total amount will be required on the day of the surgery. Payment of deductible, co-pays, co-insurance, or non-covered services may be required in addition to this amount. The Center may ask for proof of income as verification prior to agreeing to a payment plan. If an extended payment plan has been offered to the patient, monthly payments will be required or the payment plan will be considered void.

**CANCELLATION FEES:** Patients may be subject to a \$100.00 cancellation fee if they don't call to cancel, reschedule or if they fail to show up for their scheduled procedure. We appreciate a minimum of 2 business days for cancellation notifications.

### **THE BILLING PROCESS**

The Center files an insurance claim shortly after the date of service.

The Center will file a second claim if it does not receive a response from the insurance carrier. A statement regarding payments will be sent to the patient after the Center receives a response from the insurance carrier, and there is a patient liability due.

A billing statement covering medical services rendered will be mailed to the patient on a monthly basis. After 120 days, the Center will begin collection proceedings. Patients are responsible for any associated collection costs.

***The Center will accept cash, checks, VISA, or MasterCard as payment.***

(please **turn over**, date & sign)

**Anesthesia**

Anesthesia services are provided by Certified Nurse Anesthetists, sub-contracted by Bryn Mawr Medical Specialists Association, and billed separately from the Center & Gastroenterologist's charges.

**Collection Balances**

If patient's have a collection balance or are presently in collection, the Medical Director may use his discretion as to whether to allow services to be provided to the patient at the Center. The patient may be required to pay any previous balance in full prior to being rendered further procedural care. The patient will be responsible for payment of co-pays, deductible, etc., on the day of the procedure.

**Pathology**

All biopsy specimens are forwarded to an independent pathology lab for analysis. It is the policy of these laboratories to issue a separate bill for their services. Based upon insurance contracts and physician preferences, biopsy specimens will be sent to one of the following labs:

- Dianon Systems, Inc.
- Robert S. Smith, M.D. PC d/b/a Boston Scientific Pathology
- BMMSA Dept. of Gastroenterology
- Inform Diagnostics (formerly Miraca Life Sciences)
- Main Line Health Laboratories
- Chester County Hospital Dept. of Pathology
- Quest Diagnostics

By my signature below, I acknowledge that I have received the aforementioned agreement provided by Bryn Mawr Medical Specialists Department of Gastroenterology prior to the date of my procedure, or if my procedure has been scheduled the same day as my referral, I have received the notices prior to Bryn Mawr Medical Specialists Endoscopy Center obtaining informed consent for the procedure to be performed.

Signature \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or Surrogate Signature

Printed Patient or Surrogate Name \_\_\_\_\_

If Surrogate, Relationship \_\_\_\_\_

\*Time \_\_\_\_\_  
\*Complete only if receiving notice on the same day as the referral for the procedure.