Dayton Gastroenterology, LLC.
powered by OneGI

Thank you for choosing Dayton Gastroenterology as your health care provider. Please understand that payment of your bill is considered a part of your treatment. We welcome the opportunity to discuss any aspect of our Financial Policy with you or your legal/authorized representative. Please review the following information as it details your patient financial responsibilities.

**INSURANCE:**

- Insurance coverage is a contract between you and your insurance company. Patients must understand policy provisions.
- Patients using a private insurance carrier or government sponsored program must present current insurance cards and photo ID prior to services being rendered.
- Dayton Gastroenterology will file an insurance claim as a courtesy on each patient's behalf but cannot guarantee payment of claims, accept responsibility for collecting payment, or negotiate settlement on a disputed claim.
    - A reduction or rejection of your claim by the insurance company does not relieve patients of financial obligation.
    - Professional services are rendered and charged to the patient, not the insurance company. Patients are responsible for payment in full on all services rendered.
- Needs for referrals and/or authorization services related to their current appointment must be verified by patients with their insurance plans.
    - Appointments will be rescheduled should a referral and/or authorization not be obtained prior to the patient's appointment date.
- If a patient's insurance company pays only a portion of the bill or rejects the claim, any contact or explanation should be made to the patient who is the policyholder.
    - Not all services are a covered benefit in all insurance plans.

**COPAYMENTS, DEDUCTIBLES, & NON-COVERED SERVICES:**

- All copayments, deductibles, and payment for non-covered services are due at the time services are rendered.
    - Please bring a method of payment in preparation for your appointment.
    - Dayton Gastroenterology does no wave copayments, deductibles, or other patient balances.
- If Dayton Gastroenterology does not participate with a patient's insurance plan or if the patient does not have health insurance coverage, payment in full is due at the time all services are rendered.
    - If a patient is unable to pay required co-pay, deductible or any self-pay fees, the appointment may be rescheduled.

**COMMUNICATION:**

- Communication regarding a patient's account may be necessary to ensure the account remains in good standing.
- The undersigned provides authorization to receive communication regarding his/her account from Dayton Gastroenterology, its affiliates, and/or business partners through multiple methods to include, but not limited to, postal mail, voice call, call via auto-dialer, pre-recorded voice messages, SMS messages, and email to any landline phone, cell phone, or email address provided.

**NON-PAYMENT & ACCOUNTS REFERRED TO COLLECTIONS:**

- If a patient account becomes delinquent and the patient has not responded to our collection efforts, the account will be turned over to an outside source for collecting the full balance due:
    - Patient will be responsible for all additional fees related to that expense (i.e., applicable court costs and legal fees).
    - These fees will be in addition to the any existing overdue balance.
    - If a patient cannot pay the balance in full, any future appointments will be rescheduled until the patient balance has been paid or the patient has set up a payment plan with our billing office.
    - We encourage patients to contact our billing team at 937-320-5050 option 4 for payment assistance.
    - A patient's failure to pay off a balance or to initiate a payment plan may lead to the patient's dismissal from the practice.

**RETURNED CHECKS:**

- All returned checks are subject to a service fee of $35.00.
- Returned check fee(s) must be paid in full prior to scheduling future appointments.

**MISSED APPOINTMENTS:**

- Patients unable to keep a scheduled appointment must notify us at least 24 to 48 hours (based on type of service) in advance to cancel and/or reschedule the appointment. This notification allows us time to offer another patient an opportunity to be seen.
- Patients must make every effort to be on time for appointments and to arrive early to complete any necessary paperwork.
- A $25.00 fee will be incurred for clinic appointments not cancelled and/or rescheduled at least 24 hours in advance.

- Procedure appointments not cancelled or rescheduled at least 48 hours in advance will incur a $250.00 charge.
- Cancellation charges are not covered or paid by any insurance company and will be billed directly to the patient.
    - All cancellation fee(s) must be paid in full prior to scheduling future appointments.
- We may ask for a credit card at time of scheduling to keep on file to cover the missed appointments.

**MINOR AGE PATIENTS:**

- Treatment for unaccompanied minors will be denied unless charges have been pre-authorized prior to date of service.
    - Parents, guardians, and adults accompanying a minor are responsible for payment in full.

**CAPSULE ENDOSCOPY SERVICES:**

- If indicated by a provider, patients may receive a patency or "test" capsule prior to a capsule endoscopy procedure.
- Patency capsules are not covered by insurance and related costs will be billed to patients as a noncovered service.

**DISABILITY FORMS:**

- Disability, FMLA, Life Insurance and other forms require review and completion of detailed medical history by clinicians.
    - Please allow 5-7 days for completion of these forms.
    - A $35.00 fee applies for completion and payment must be made in full upon submission to our office.

**MEDICAL RECORDS REQUESTS:**

- Requests for copies of medical records will be processed upon receipt of a completed Medical Records Request Form. Any applicable fees must be paid prior to processing.
    - Please allow us (5) business days to complete all requests.

**FEES:**

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| FMLA, Disability, and Miscellaneous Forms | $35.00 |
| Missed Office Appointment - Fee assessed if appointment not cancelled with at least 24 hours notice | $25.00 |
| Missed Procedure Appointment - Fee assessed if appointment not cancelled with at least 48 hours notice | $100.00 |
| Returned Checks | $35.00 |
| Medical Records Release - Electronic copies provided for personal health record No Charge | NA |
| Medical Records Release - Paper copies | |
| Pages 1-10 | $3.51/pg |
| Pages 11-50 | $0.73/pg |
| Pages 51+ | $0.29/pg |

**AFFILIATIONS:**

- Patients may receive statements from multiple entities after having a procedure.
- Although the physicians of Dayton Gastroenterology may have shareholder interest in external procedure centers, patients may receive separate statements for fees associated with professional services, facility, pathology, infusion services, or other diagnostic testing.
- If a patient has a procedure performed by any of our physicians at an ambulatory surgical center or a hospital, the patient will receive a bill from that facility for its facility fee as well as from Dayton Gastroenterology for applicable professional and ancillary services.

**PATIENT ACKNOWLEDGEMENT:**

I have received, reviewed, and understand the Dayton Gastroenterology financial policy and I agree to be bound by each of its terms and conditions. I also understand and agree that such terms may be amended by the practice from time to time. I understand that I am financially responsible for all charges regardless of payments made by my insurance. I hereby authorize Dayton Gastroenterology to release medical information to my insurance company to secure payment of benefits. I also authorize the use of this signature on all insurance submissions and as authorization for payments to be sent to Dayton Gastroenterology. This signature authorizes release of medical records to any physicians or health care facility when referred or requested by them for continuity of care. I voluntarily consent to medical care including the routing of diagnostic testing, surgical procedures, and additional medical treatment.

Patient Name (please print) _____ Relationship _____

Patient Signature (or Responsible Party) _____ Date _____