



Financial Policy

I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay copayments, amounts applied to deductibles, and balances of bills not paid in accordance with the benefits of my current health insurance policy. Copayments are due at the time services are rendered. If I am unable to make payment in full for my medical treatment for any reason within 30 days of receipt of services, I agree to call the business office and make payment arrangements. Any balances that are 60 days past due may be sent to collections.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to Gastro Centers of Pennsylvania, LLC, and Malvern Endoscopy Center, LLC, for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy.

I understand that payment is my sole responsibility, and that in the event of non-payment for whatever reason by any third party which I direct Gastro Centers of Pennsylvania, LLC, and Malvern Endoscopy Center, LLC to bill, I will pay immediately.

You expressly consent and agree that, in order to discuss or provide services for your account(s) (the "Accounts") or to collect amounts you may owe, Gastro Centers of Pennsylvania and Cumbria Capital MSO, LLC and its officers, agents, affiliates, employees, first and third party debt collection agencies, and any affiliated or business associated service providers or vendors of any of these parties, associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You confirm that any telephone number provided is associated with you and not a third party. You expressly consent and agree that We may also utilize your information to contact you via mail, email using any email address you provide to us, text message, or prerecorded or artificial voice or voice messages, via predictive or automatic dialing methods, systems, or devices, and pre-recorded or artificial voice announcements or prompts at any telephone number associated with the Accounts, including landlines, wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

CANCELLATION AND NO SHOW POLICY

We understand that from time to time you may need to cancel an appointment for various reasons. Please observe the rules regarding cancellations stated below.

1. Any modification of schedule requires at least **2 business days** notice for **clinic/office appointments** and **5 business days**, for **procedure appointments**.
2. Cancellations that are made without appropriate notice are subject to a patient charge of \$50.00 clinic/\$200.00 procedure.
3. If you do not show up to the scheduled appointment without notice, the above charges will be applied respectively.

If you do not show up for an appointment and there are extenuating circumstances, a Request to Waive Cancellation Fee form must be submitted through our website and approved. Patients remain financially responsible for all applicable fees unless written approval of the waiver is granted
****This is not covered by your insurance plan and you will be personally responsible for the payment, prior to scheduling your next visit****

RETURNED CHECK POLICY

A fee of \$25.00 will be assessed to any patient whose check is returned due to insufficient funds.

By signing below, you acknowledge receipt of our Financial Policy.

Patient or Legal Guardian Name

Patient or Legal Guardian Signature

Date