Metro
Atlanta
Gastroenterology

Metro Atlanta Endoscopy, LLC

Metro Atlanta Endoscopy, LLC

Re: Important Financial Information

Dear Patient,

Metro Atlanta Gastroenterology will make every possible attempt to notify your insurance carrier of your upcoming procedure(s) and obtain the necessary 'Pre-Certification' and approval**.**

We strongly recommend that you contact your insurance company to review your benefits well in advance of your procedure.

It is important that you understand that you are responsible for the following:

> **Contacting your insurance carrier prior to your procedure(s) regarding your Benefits, Deductible, Co-Insurance, and or Co-pay. Our policy is to collect 50% of patient responsibility approx. 48 hours before your procedure and the other 50% at the time of your procedure.**
>
> In the event that you are unable to make your scheduled appointment; we require **72 hour notification (3-business days),** that you have elected to cancel/reschedule your procedure. Failure to do so will result in receiving a bill for a **$250.00 No Show Charge.** {Cancellation/Rescheduling will not be accepted via the Answering Service, you must call (404) 255-9184}.

The fee for services quoted by our office is an **estimate** of the Physician ***and*** Facility fee for the recommended procedure(s), based on information obtained from your insurance carrier. It is possible that the level of service may increase during your procedure to a higher level of care. This would be at the discretion of your physician in order to provide you with the highest level of quality care. In the event such changes occur, your insurance carrier will be billed accordingly, and any associated patient responsibility will be billed as required.

In addition to receiving a bill for the physician, you may receive a bill from the:

- Hospital
- Anesthesiologist
- Pathologist.

By signing my name I acknowledge that I have read and understand my responsibilities, and agree to the terms. **I also understand that I must have a driver with me for my procedure if I am going to have sedation. The driver must sign you out and accept responsibility for your safety.**

Patient Signature: _____ **Date:** _____

03/21/14