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FINANCIAL POLICY

We, the staff of Digestive Health Center of Michigan thank you for choosing us as you GI specialist. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship. Our goal is to inform you of the aspects of that financial policy and to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact the office manager at 586-598-5731.

INSURANCE: We will file claims for all professional services provided by Digestive Health delivered in the office or at the hospital. It is with the understanding and consent of the patient that all benefits will be assigned to Digestive Health Center of Michigan; insurance carrier deductibles, co-pays and non-covered services are the responsibility of the patient. Please note that your insurance company has the right to deny payment of office visits and procedures. For patients requesting open endoscopy with-out prior office visit, doctor may request an office visit if medically necessary, in his opinion.

If you have no insurance coverage or are unable to pay at the time services are rendered, we will work with you to make financial arrangements. We will request a payment for outpatient procedures prior to having the procedure performed.

COPAYMENT & RETURNED CHECKS: Please understand that payment for services in an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or if you participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance.
We make payment as convenient as possible by accepting cash, check, money order, MasterCard, Visa and Discover. A $35.00 services fee will be charged for all returned checks; **also a $5.00 statement fee will be added to your bill if copay is not paid at the time of service.**
PATIENT STATEMENT: I have been informed of the financial policy of Digestive Health Center of Michigan and agree to its terms. I have been notified that my insurance company may deny payment for an office visit and I agree to be personally responsible for payment.

Signature____ **Date:** _______________