8221 ROCHESTER AVENUE SUITE 130
RANCHO CUCAMONGA CA 91730
PHONE 909-301-4047 FAX 833-989-2428

FINANCIAL POLICY

Name__________________________ Date of Birth______________ Todays Date____________

Thank you for choosing us as your health care provider. We are committed to providing you the best possible medical care.
Please understand that payment of your bill is important. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Regarding Insurance: As a courtesy, our office will bill your insurance for the services you will receive. We cannot bill your insurance company unless you give us correct insurance information. It is your responsibility to inform us if your insurance has changed at any time during treatment. Please understand that your bill is ultimately YOUR responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full in a timely manner, it will then become your responsibility to pay the balance. You will be charged a $25 fee for any returned check. Any account over 90 days old without payment is subject to being sent to a collection agency.
We strongly encourage you to personally contact your insurance company about your co-pay, co-insurance and deductibles. You must understand what your insurance benefits cover and how this may affect you financially.
Co-pay, Deductible and Co-insurance: Your insurance Co-pay, unmet deductible and estimated co-insurance amounts are due prior to service. Failure to pay may lead to rescheduling or cancellation of appointment. Payment Methods: We accept Cash, Check, Credit cards (Visa, MasterCard, and Discover).
Referrals and Pre-authorization: If your insurance company requires a referral/prior authorization from your primary care physician, you must present this referral to our staff before being seen. If you do not obtain a referral when your insurance company requires one, you will be required to pay in full for the visit or service. It is YOUR responsibility to make sure a referral has been obtained for any procedures as well.
Missed Appointments and Cancellation Fee: Due to the amount of time allotted for scheduled endoscopic procedures, we do request at least 2 working days notice for cancellation of any procedures. It is our policy to charge a $100.00 cancellation fee if given less than 2 working days notice. The charge for a late cancellation/no show for procedure will be billed directly to you and not to your insurance. Please help us serve you better by keeping scheduled appointments.
Ancillary Services: Please be aware that there may be a charge involved for ancillary services such as completing disability forms and/or forms related to your care, and formulating letters on your behalf.
Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I authorize NEBI PC or my insurance company to release any information required for processing my insurance claim. I also authorize my insurance benefits to be paid directly to the physician. I have read the Financial Policy in full and I understand and agree to this policy.

Signature of Patient/Guardian__________________ Date____________________________