Payment Policy

EAST CAROLINA GASTROENTEROLOGY, P.A.
EAST CAROLINA GASTROENTEROLOGY ENDOSCOPY CENTER

4 Office Park Drive
Jacksonville, NC 28546
Telephone (910) 353-6158

Thank you for choosing us as your health care provider. We are committed to providing you with a successful course of treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Payment Policy, which we ask you to read and sign prior to any treatment.

We can bill your insurance plan(s) only if you give us complete information as required by your plan. Most insurance companies will receive two bills; one from our clinic and the other from the Endoscopy Center owned by clinic physicians. **If you cannot supply us with sufficient insurance information at the time of the visit, we will consider the entire bill to be the patient's responsibility, and full payment will be due at the time of service** .

You or your insurance may also receive a bill from a pathology lab if we collect samples during your endoscopy, and from Carolina Anesthesia Associates(CAA) if you received anesthesia. The clinic or the endoscopy center is not affiliated in any way with the pathology lab or with CAA.

On rare occasions our clinic or the Endoscopy Center may not participate with your insurance carrier. It is your responsibility to verify this prior to services being rendered. If services are out of network you may be responsible for unpaid balance from your insurance company. You may also receive a check from your insurance company as payment for services we provided. We expect this check to be submitted at our office within three days of your receipt.

Patients with Insurance
All co-payments, deductibles, coinsurance, and charges for non-covered services are due at the time of service. We accept cash, checks, debit card, or any major credit card.
Any charges not paid by insurance will become the patient/responsible party's responsibility.

Patients without Insurance
Payment in full is due at the time of service. We accept cash, checks, debit card, or any major credit card.

Default
Regardless of insurance coverage, if after default, your account is placed in the hands of an attorney or collection agency for collection, the undersigned agrees to pay all attorney and/or collection fees, together with all additional cost and expenses of collection to the present extent of the law.

Thank you for taking the time to read and understand our Payment Policy. Please let us know if you have any questions or concerns ***before*** signing below. Your signature indicates that you have read this policy and understand and agree to its terms. **A detailed statement of all your charges is available upon request.**

I hereby state that I have read, understand, and agree to the terms of this policy.

X_____ _____
Signature of patient or responsible party Date