Patrick G. Tempera, M.D.
Kunal Grover, M.D.
Prakriti Merchant, M.D.
Daniel Bodek, D.O.
Michael Margolin, M.D.
Tracy Alves, DNP
Rajesh Dhirmalani, D.O.
Michael J. Viksjo, M.D.
Arun R. Mathew, M.D.
Robert I. Greenblatt, M.D.
Guida St. George, PA-C.

**ADVANCED GASTROENTEROLOGY GROUP**

Thank you for choosing Advanced Gastroenterology Group for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our financial policies.

**Patient Financial Responsibilities**

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment of care.
- If your insurance requires a referral, it is the patient's responsibility to obtain the referral and present at their office visit. **If a visit or procedure is denied due to no referral, the patient is responsible for payment.**
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patient are responsible for payment of co-pays, co-insurance, deductibles and all other procedure or treatment not covered by their insurance plan.
- **Co-pays are due at the time of service.**
- Co-insurance, deductibles and non-covered services are due 30 days from receipt of billing statement.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - **Returned Checks Charge - $20.00**
    - **No Show Fee - $50.00 for office visit and $100 for procedures**

We are aware that emergencies occur, however, it is your responsibility to notify our office 24-48 hours that you will not be able to keep your office or procedure appointment.

By my signature below, I hereby authorize assignment of financial benefits directly to Advanced Gastroenterology Group. I understand that I am financially responsible for all charges not covered by this assignment.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____