



Henry Levine M.D. | William Ruderman M.D. | William Mayoral M.D.
Marlon Ilagan M.D. | Samuel Giday M.D | Jason Korenblit M.D

1817 North Mills Ave. Orlando Fl. 32803

Account# _____

Patient: First Name _____ Last Name _____ DOB _____

Address: _____

Contact: Tel# _____ Cellphone# _____

Referring Dr: _____ PCP: _____

Tel# _____ Tel# _____

Reason for today's visit _____

Last Colonoscopy: _____

FINANCIAL POLICY

The doctors and staff of Center for Digestive Health and Endoscopy would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visit as convenient as possible. We ask for your help by understanding and cooperating with our financial policy.

Please read this policy and sign below confirming you understand the following:

- All payments are due at the time of service: Self pay fees, Insurance co-payments and deductibles...Any open balances such as, co-insurances and deductibles will be collected at service date. Payable by cash, check, Visa, MasterCard, Discover or American Express.
- A return check will result in a \$25 service charge and all future payments will be collected in the form of Cash or Credit Card.
- Refunds request may take up to 4 weeks from date requested, if there is no pending claims.
- There is a \$25 charge for completion of paperwork (ex: disability, FMLA etc). Paperwork may take up to 7-14 days for completion.
- Any balance over 90 days old will be processed and sent to a collection agency.
- Our practice participates with several insurance companies; it is your responsibility to understand the requirements and covered benefits of your plan.
- You are responsible for any non-covered and/or denied claim; you will receive a statement of denied charges and payment is due in 30 days after date of statement.
- If your insurance policy requires a referral, it is your responsibility to contact your primary care physician and have a referral faxed to our office prior to your appointment date.
- It is your responsibility to notify our office of any changes to your insurance coverage, your address and telephone number.
- You are required to cancel office appointments 24 hours prior to appointment time to avoid a \$25 cancellation charge and 48 hours prior for procedures to avoid a \$100 cancellation charge.

We realize that temporary financial problems may affect timely payment of accounts. If such problems arise, we urge you to contact us promptly for assistance in the management of your account. Contact our professional staff in the Business Office; we are here to help you with any questions and issues. Call 407-896-1726

I have read and understand the above Financial Policy and agree to meet all financial obligations.

Patient Signature _____

Date _____