COLON AND RECTAL ASSOCIATES, LTD.

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Billing Policy of Colon and Rectal Associates, LTD

Thank you for choosing Colon and Rectal Associates, LTD. Our mission is to exceed your expectations by providing high quality care and achieving patient satisfaction. Your health and well-being are of the utmost importance to us. We have recently updated our billing policy. The cost of providing high quality care continues to rise and these changes are necessary to ensure that your needs are met. Effective March 1, 2025 our billing policy will be as follows:

1. **All co-pays and prior balances are due in full at time of service in order to be seen.** Please contact your insurance company directly with any questions you may have regarding your financial obligation for specialist services.
2. **All referrals are due at time of service in order to be seen.** We suggest you contact your PCP prior to your appointment with our office to confirm a referral was sent. Please request the confirmation number and date the referral was issued. **Our NPI number is 1639124720**.
3. At Colon and Rectal Associates, LTD., we maintain a Zero Balance Office policy to streamline our billing process and ensure timely payment for services rendered. As part of this policy, all patients are required to place a valid credit, debit, or HSA card on file with our office. This card will be used to settle any outstanding balances promptly, including co-pays, deductibles, and any other charges not covered by your insurance. This practice helps us minimize administrative costs and allows us to focus on providing the highest quality care to our patients.
4. **Please be advised that we are not a participating provider for any Medicaid and/or state funded insurance plans. If you choose to have services with any of our physicians/providers, you will be responsible for the balance.**
5. **There will be a $50.00 fee for missed office appointments without prior notice. There will be a $250.00 fee for missed or canceled surgical procedures if 48 hours' notice is not provided.**
6. **There will be a $25.00 fee for the completion of all disability forms.**

We apologize for any inconvenience this may cause. However, no exceptions can be made as that would be a violation of our insurance contracts. As per the contractual agreement with our insurance carriers, we are unable to see patients without a co-pay or referral. Please sign and date this document and return to the office prior to your next appointment. If you have any questions regarding this policy please contact the office manager, Kelly Smith at 215-517-1250.

I have read and understand the Billing Policy of Colon & Rectal Associates, LTD. I agree to pay for any balances resulting from services provided to me. ***You must select one of the payment options below.***

☐ ***I agree to keep my card on file with the practice. I understand that my card will be charged if needed.***

OR

☐ **I agree to pay the retainer fee of $200 (office visit) or $500 (surgical procedure). Any account credits will be refunded at the completion of your treatment(s).**

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____

By typing your name on the signature line, you agree with the terms and conditions of the document.

REV: 3-1-25