Acadiana Pediatric Gastroenterology and Hepatology Associates
4630 Ambassador Caffery Parkway, Suite 406, Lafayette, LA-70508

Statement of Patient Financial Responsibility

Patient Name: ____ **DOB:** ______________________

The Acadiana Pediatric Gastroenterology and Hepatology Associates appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Acadiana Pediatric Gastroenterology and Hepatology Associates, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Acadiana Pediatric Gastroenterology and Hepatology Associates, the full and entire amount of bill incurred by me or the above named patient.

Patient Signature ____ Date __________________________

Guarantor Signature ____ Date __________________________
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature ____ Date ____________________________

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Acadiana Pediatric Gastroenterology and Hepatology Associates. I agree to pay Acadiana Pediatric Gastroenterology and Hepatology Associates, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature ____ Date ____________________________

Payment Plans

Payment plans are available, at the discretion of Acadiana Pediatric Gastroenterology and Hepatology Associates on a weekly, monthly or bi-monthly basis.

Delinquent Accounts

All Delinquent accounts will be submitted to a Debt Collection agency/ attorney for collections.