



Financial Policy

It is the policy of Borland Groover to provide our patients with access to the highest quality gastroenterological care available. In order for us to do so, we must ensure that we are able to meet our operational expenses. We ask that you read, understand, and sign our Financial Policy prior to receiving treatment.

PAYMENT AT TIME OF SERVICE

As a courtesy, we will bill your insurance for all services; however, we ask that you pay any portion of your costs not covered by your insurance due to deductibles, co-insurances or co-payments on the day of service. Billing for these items is not only costly, but our statements often go unpaid. This results in increased costs to both you and other patients.

MEDICAL FORMS

Patient request for physician/clinical staff to complete employer medical related forms/letters will be charged a fee of \$25, per form. Fee must be paid by cash/credit card at time of request.

SUBMISSION OF CLAIMS

Your health insurance plan is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, charges not paid by your insurance company are your responsibility. Working together, we can resolve most insurance issues in a mutually acceptable manner; nevertheless, it is the patient's responsibility to understand his or her policy limitations. In the event your health insurance determines that they will not cover a service that you have received, you will be responsible for payment.

OUTSTANDING BALANCES

We urge you to keep your account current to avoid any misunderstandings with our office. When an account balance becomes more than 45 days past due, it will be referred to an outside collection agency. At that time, any additional fees incurred on the account will be the responsibility of the patient. If you need to make special payment arrangements, it is your responsibility to contact one of our financial counselors before your account is sent to an agency. Minimum monthly payment arrangements may be made for no less than \$50.00 unless approved by the Director of Finance. As a last resort, patients who fail to make payments could be terminated from the practice.

PAYMENT OPTIONS

You will receive monthly statements. The amount shown in the "PLEASE PAY THIS AMOUNT" box is your financial obligation. It is due and payable upon receipt. For your convenience, we accept payment in the form of check and from Visa, MasterCard, American Express and Discover. Payments may be made on our website at www.borlandgroover.com, called in at 904-398-2183, or mailed to 4800 Belfort Rd, Jacksonville, FL 32256.

CHARITY CARE

Our financial counselors are available to assist our patients in applying to receive charity care. This may be available for those who earn up to 200% of Federal Poverty Guidelines.

RETURN CHECK, NSF, CLOSED ACCOUNTS

Payments made to Borland Groover that are not honored by the bank will incur a return check fee of \$50.00. If failure to pay check and fee within 15 days of receiving return check, notice from Borland Groover account will be turned over to the State Attorney's office.

Patient Name _____ Patient Signature _____ Date _____

By signing above, you agree to all the terms and conditions contained herein.