

NORTHEAST GASTROENTEROLOGY ASSOCIATES,
P.C

52 Stiles Road, Suite 110
Salem, NH 03079

Financial Arrangements and Insurance Agreements

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any services rendered at Northeast Gastroenterology Associates, P.C. / hospital. I realize that I am responsible for all collection costs and / or attorney costs incurred by Northeast Gastroenterology Associates, P.C. In an effort to collect my bill. Also if you are being seen for a gastroenterology related issue it is your responsibility to make sure that you have a referral for your visit from your Primary Care Physician, failure to do so will leave you responsible for the services rendered at this office and any hospital facility appointments that are booked.

MEDICARE WAIVER

Medicare will not pay for services that are considered non-covered services under Medicare guidelines. In addition, Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered , in not reasonable and necessary under the Medicare program standards, Medicare will deny payment for that service. If Medicare denies payment, I agree to be personally and fully responsible for payment.

I AGREE TO THE TERMS OF THE FINANCIAL AGREEMENT AND INSURANCE OF THE WAIVER FORM.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I was provided with the Notice of Privacy Practices of the medical Practice named above. (Copy of such report is in a white binder next to the secretary window).

Print Name of

Patient: _____

Signature of

Patient: _____

Date: _____

Patient's Date of

Birth: _____