GANV
GASTROENTEROLOGY ASSOCIATES
OF NORTHERN VIRGINIA
Leaders in gastrointestinal and liver care.

703-698-8960
www.novagi.com

FINANCIAL AND PRACTICE POLICIES

Referrals and Authorizations:

1. I understand that it is my responsibility to contact and secure from my insurance plan any referrals, pre-certifications or authorizations prior to receiving any non-emergency medical services from Gastroenterology Associates of Northern Virginia (hereafter referred to as "GANV"). If a referral is required and I don't bring it with me, my appointment may need to be rescheduled. If a referral is required and I do not provide one, I accept full responsibility of all charges and fees billed by GANV.

Financial Agreement:

1. GANV will file for insurance benefits and accept payments per contractual agreements with participating insurance companies. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the subscriber/policyholder and the insurance company. Any assistance granted by GANV is given strictly as a courtesy.
2. I understand that I will be billed separately for "non-covered" or "incidental" services related to patient care, including but not limited to: telephone and/or email consultations, emergency prescription refills or other convenience-oriented care rendered.
3. I understand there will be a charge for medical records or any medical forms which need to be filled out by the physician.
4. I agree to pay a $50.00 fee for missed appointments not cancelled twenty-four (24) hours prior to the scheduled appointment and a $100.00 fee for any procedures not cancelled three (3) business days prior to the scheduled procedure.
5. Should any balances arise due to insurance co-payments, co-insurance, deductibles, insurance denials, termination of coverage, non-addition of a dependant to insurance plan, non-payment at time of service and/or any other reason, I understand that I will be billed for these costs and agree to pay all charges within thirty (30) days of billing date. Interest of one and one half percent (1.5%) per month, eighteen percent (18%) per annum, may be charged on all delinquent accounts over sixty (60) days.
6. If the balance is not paid within sixty (60) days of the billing date, or if agreed upon payment arrangements on my account are not made, GANV may retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my delinquencies. I understand that I will be responsible for all additional fees incurred from that attorney and/or collection agency.
7. I agree that if for any reason a check is returned on my account, I will be responsible for a $25.00 returned check fee in addition to the original fees for services.

Certification of Insurance and Billing Accuracy:

1. I certify that the information I have reported with regard to my insurance coverage is correct.
2. I agree to inform GANV immediately of any change in insurance coverage and/or benefits and change of personal information.

Advanced Directives

1. GANV acknowledges a patient's right to have an Advanced Directive (www.caringinfo.org/i4a/pages/index.cfm?pageid=3289) and will file any advanced directives provided or brought to our attention in the patient's medical record and the record flagged accordingly.
2. I understand that it is the policy of GANV physicians and staff that in the unlikely chance of a patient experiencing an urgent medical event while in the office or endoscopy center, that patient will be stabilized and transported to the closest hospital with a copy of the Advanced Directive if made available to GANV.

Practice Policies:

1. **TEST RESULTS** may take up to two (2) weeks. The results will be sent by letter unless there is cause for more immediate action, in which case you will be notified by phone.
2. In an effort to reduce call volume, please leave only one **PHONE MESSAGE**. Multiple phone messages only overload the phone system and will not ensure a return call any sooner. To better serve you, we ask that when leaving a voicemail message you clearly state the patient's name, spell the last name, give the patient's date of birth and a phone number where you can be reached easily.
3. Any **FOLLOW-UP APPOINTMENTS** should be made while checking out. The schedule usually fills up quickly and may take up to 6-8 weeks for a return appointment.
4. In an effort to see patients on time, we request that new and follow-up patients arrive at your scheduled check-in time. If you arrive later than the check-in time, you may need to be rescheduled.

Patient Signature _____ Date _____

Print Patient Name _____ Date of Birth _____