LAKESIDE
GASTROENTEROLOGY

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Lakeside Gastroenterology Billing and Payment Policy

- Patients are expected to pay off their balance due in full at their time of their office visit before they can be seen by a physician.
- Lakeside Gastroenterology will send one statement free of charge to patients; any additional statements will have a $2.00 surcharge for the maximum of three statements.
- After three statements and we do not receive your payment in full, we will send your account to collections. To prevent you account from being sent to collections, you can set up a payment plan with us, if you fail to make any payment while on a payment plan, your account will be sent to collections.
- Any patient whose account is at collections will not receive care from Lakeside Gastroenterology including prescription refills, prior authorizations, office visits, etc.
- All charges incurred by Lakeside Gastroenterology for your account being sent to collections will be the patient's responsibility. So please pay off your balances when due or set up a payment plan with us.
- The providers of Lakeside Gastroenterology may refer you or take you to other facilities for treatment/procedures and or testing which these providers may have vested interest or earn profit from them. These facilities are independent from Lakeside gastroenterology.
- You agree, in order for us to service our account or to collect any amounts you may owe, render your care, our organization's representatives, ancillary providers, HIPPA business associates, vendors, and the representatives of our debt collection agency, may contact you by any telephone numbers associated with your account including wireless telephone numbers, which result in charges to you, These representatives may also contact you by sending text messages or emails, using any email addresses you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device as applicable. I/we have read this disclosure and agree that the lender/creditor, its ancillary providers, HIPPA business associates, vendors and its debt collection agents and all the above may contact me/us describe above.

- Patients Name:_____

- Signature:_____
  Date:_____