GI Excellence, Inc.

Gastroenterology Associates

Office Fax: (951) 658-6476 · Office Hours: 9 a.m. to 5 p.m, M - F

Milan S. Chakrabarty, M.D.
General Gastroenterology

Indraneel Chakrabarty, M.D., M.A.
Advanced & Interventional
Gastroenterology

Sandra Del Valle, PA-C
Gastroenterology Physician Assistant

Kathleen A. Linke, PA-C
Gastroenterology Physician Assistant

Two Locations:

HEMET
1003 E. Florida Avenue · Suite 101 · Hemet, CA 92543 · (951) 652-2252

TEMECULA
44274 George Cushman Ct. · Suite 208 · Temecula, CA 92592 · (951) 383-6001
(By appt.)

NOTICE OF PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing GI Excellence as your healthcare provider.

Please read the following information regarding insurance coverage and your fi nancial responsibility. Although we will make every attempt to verify your insurance coverage and benefi ts, it is also your responsibility to understand your coverage. Despite these efforts, if for any reason your insurance company does not pay, you may be fi nancially responsible for your healthcare services.

Insurance Coverage:

It is your responsibility to understand your insurance coverage and benefi ts. We will assist in verifi cation of your coverage and benefi ts and exclusions, but if for any reason your insurance does not make payment, you may be fi nancially responsible for balances.

Insurance Changes:

If you have had any changes to your insurance carrier, it is your responsibility to notify us immediately and prior to your services being provided. If your coverage is not in effect for the date of your service, you will be responsible for the balance.

Co-payments, Co-Insurance and Deductibles:

Co-Insurance and Co-Payments are the patient's responsibility and are due at the time of service. Deductibles are the responsibility of the patient and are determined by your insurance coverage. We will attempt to determine the amount that you will be responsible for prior to your service, but since this will vary depending on other healthcare services that you have received recently this amount may differ and amounts may become due after we receive payment from your insurance company. We will send you a statement with the balance due. This information will also be available on the Explanation of Benefi ts you will receive from your insurance company. Returned checks will be charged a service fee of $35.

Referrals:

Your insurance company may require obtaining a prior authorization for services. We will assist in obtaining the referrals needed. If you have changed you primary care physician it may be necessary to obtain a new referral, so please let us know each time you change your primary care provider.

Non-Covered Services:

Patients are responsible for all "non-covered" services if they are denied by your insurance company. Please be aware of exclusions to your coverage.

Insurance Forms/Requests:

You are responsible for timely responding to requests from your insurance company. Failure to do so will result in a denial of payment to us and you are responsible for the payment.

Insurance Payments:

If an insurance payment is sent to you in error please forward the payment along with a copy of the Explanation of Benefi ts to our offi ce within 10 days of receipt.

We appreciate the confi dence you put in us to provide you with excellent healthcare.

I have read and understand this fi nancial responsibility form.

Patient Name _____

Signature _____

Date_____