LANDMARK
DIGESTIVE HEALTH

2851 New Hartford Road, Suite A
Owensboro, KY 42303
Phone: 270-922-2500
Fax: 270-922-2505

Billing Policy and Patient Authorization

Billing Policy:

1. As a standard practice, payment is required at the time services are rendered and is the responsibility of the patient, parent, or guardian. Our request for payment will include any deductibles, co-pays, and co-insurance amounts that apply to your visit.

2. If you anticipate problems paying your portion of your bill, please let us know as soon as possible so payment alternatives that may be available to you can be reviewed.

3. Unless other arrangements are made, any unpaid balances are due within 30 days of receipt of the invoice. Payment is accepted in the form of cash, check, credit card, or money order.

4. Any appointment missed without prior notification may be subject to a $25 cancellation fee.

5. Any check payments returned by the bank for non-sufficient funds will result in a $30 fee.

6. Any overpayment to an account will be promptly refunded to you after all claims have been processed by all applicable payers.

7. Should you have a change in your insurance, it is the sole responsibility of the patient to notify us of these changes immediately.

Patient Authorization:

I, _____ (print name), hereby authorize Landmark Digestive Health, PSC to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made directly to Landmark Digestive Health, PSC (or in the case of Medicare Part B benefits, to myself or the party who accepts assignment.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the billing agent (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

I authorize the provider or designated representative to contact me by telephone about appointments, billing, and medical care.

As the patient or parent or guardian, I agree to the above terms and conditions.

Signature of Patient or Guardian: _____ **Date:** _____