Digestive Disease Consultants
Alan F. Shikoh, M.D.

Financial Policy:
We are committed to providing you with the highest quality healthcare services. However, the ability of Digestive Disease Consultants to achieve this depends greatly on your understanding of our financial policy. If you have medical insurance, we will file insurance claims on your behalf. Even though we file insurance claims for you, we need your active participation in the insurance claim process. We will need up-to-date insurance information and will make a copy of your insurance card. **Please be prepared to pay any co-pay or deductible required by your insurance company at the time of service.**

Commercial Insurance Patients:
Remember that your insurance contract is between you and your insurer. If your insurance company pays only part of your bill or rejects your claim you are financially responsible for the balance and are to pay it upon receipt of your statement.

HMO Managed Care Insurance Patient:
Many HMO/Managed Care Plans required that you obtain a referral from your Primary Care Physician in order to receive care from a specialist. It is your responsibility to obtain this referral if required. If your referral is not received in our office on or before the appointment date, your appointment will be rescheduled until the referral can be obtained. You will be required to pay the co-pay for authorized services at time of services. Unauthorized services will be the financial responsibility of the patient and will be due at the time of service.

Patients with no Insurance:
A discount is available to self-pay patients without insurance coverage for office visits and diagnostic procedures. Arrangements must be made with the office manager prior to the office visit and payment is required to be paid at the time of service. If a diagnostic procedure is required the estimated charges must be paid at the time the procedure is scheduled.

Forms Policy:
There will be a $10.00 fee for FMLA forms and a $20.00 fee for disability forms to be filled out by our office. This fee is per form and must be paid in full before the forms will be completed. Please allow 7-10 days for the forms to be completed.

By signing this form, I understand the above policy and agree to pay any co-pay, coinsurance, deductible and form fees.

Patient Signature _____ Date _____