GAMIT

GASTROENTEROLOGY & ADVANCED METABOLIC INSTITUTE OF TEXAS

Thank you for choosing our clinic for your healthcare needs. We are committed to providing quality care. Please read and sign this financial policy to acknowledge your understanding and agreement.

Insurance Information:

We will bill your insurance company as a courtesy. It is your responsibility to provide accurate and current insurance information at each visit. You are responsible for knowing your insurance benefits, including copayments, deductibles, and coverage limits.

Copayments and Deductibles:

All copayments, coinsurance, and deductibles must be paid at the time of service. Payment is required regardless of insurance coverage.

Self-Pay Patients:

Patients without insurance or those choosing not to use insurance are expected to pay in full at the time of service.

Non-Covered Services:

Some services may not be covered by insurance. You are responsible for full payment of any services not covered by your plan.

Past Due Accounts:

Balances not paid within 30 days may be subject to late fees and may be turned over to a collection agency.

Appointment Cancellations:

Please notify us at least 24 hours in advance if you need to cancel or reschedule your appointment. Failure to do so may result in a missed appointment fee.

I have read and understand the Patient Financial Policy. I agree to comply with this policy and accept responsibility for any charges incurred during my treatment at Gastroenterology & Advanced Metabolic Institute of Texas.

Patient/Guardian Name: _____

Signature: _____

Date: ___ / ___ / _____

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