AE ADVANCED ENDOSCOPY & SURGICAL CENTER, LLC

142 Route 35 Suite 101, Eatontown, N.J. 07724 Phone (732) 935-0031 Fax (732) 935-0032

Note: AESC Billing can be reached at Advanced Medicine Practice Management at (866) 516-2676 Ext 122.

OUT-OF-NETWORK COMMERCIAL INSURANCE AND SELF-PAY PATIENTS:

Advanced Endoscopy & Surgical Center, LLC. (AESC) will bill your primary and secondary insurance carrier for the services you receive at our Center, in accordance with all applicable laws, rules regarding patient privacy, and security to ensure the confidentiality and safety of our patient's medical records. If AESC is out of network with your carrier, and you do not have secondary coverage with any other carrier and/or Medicare or Medicaid you will be financial responsible for all balances after your insurance carrier(s) has paid.

IN-NETWORK COMMERCIAL INSURANCE:

Please be advised that we participate with Aetna, Amerigroup, Amerihealth, ALL Blue Cross Blue Shield Plans, Cigna, Clover Health, New Jersey Carpenters, NJ Horizon Health, Magnacare, Qualcare, Tri-Care (Humana), Medicaid, Medicare, Railroad Medicare, United/Oxford, US Family Plan and Well Care. You will be billed according to your plan's benefit allowances, i.e., co-insurance/co-pay and or deductible applied. If your insurance policy is a Medicare replacement plan, it is subjected to Medicare guidelines and allowable rates. You will be responsible, and billed for any and all co-insurance/co-pay or deductible applied.

You may also receive a bill from ***AESC*** for the **FACILITY FEE** if:

1) The coverage is not actually current or payment is denied by your carrier due to pre-existing conditions.
2) You do not provide information requested by your insurance carrier after they receive our bill.
3) Your policy benefits have been exhausted (i.e., you've reached your benefit maximum.
4) Your insurance carrier mailed payment to you rather than AESC, and you did not forward the payment as instructed below.
5) We've had no response from your insurance carrier with no resolution.

IN-NETWORK PATIENT RESPONSIBILITY FINANCIAL POLICY:

Please be advised that upon receipt of payment from all of your insurance plans, you will be balanced billed for any additional patient responsibility, co-insurance/co-pay and/ or deductible that was not received at the time the service was rendered. Thirty (30) days after the initial bill has been sent to you, we will make one collection phone call to you, the patient. Next a collection letter will be sent advising that we need a response/contact to discuss the bill for payment arrangements. If we have no response to our attempt in contacting you within 14 days from the date of the letter your account balance will be sent out for OUTSIDE COLLECTION ACTIVITY, and you will be responsible for the balance, along with 30% collection fees added to the bill. You will also be responsible for any and all additional collection fees including court costs, and attorney fees incurred as a result of this debt.

AESC does not participate with all commercial insurance carriers. Payment may be made directly to the patient for the facility fee. **PLEASE DO NOT DEPOSIT THE *CHECK***. Endorse the check and forward it with the accompanying explanation of benefits to the address listed above to the attention of the Billing Office. We will receive confirmation from your insurance that they have forwarded the payment to you. If you do not tum over the check and the explanation of benefits to AESC you will be responsible for the bill IN FULL, plus any additional court fees or attorney's fees incurred in the collection of your account.

ANESTHESIA CHARGES: When procedures are performed at AESC, anesthesia services are provided, and will be billed to your insurance carrier. In the event you receive the payment from the insurance carrier, **DO NOT DEPOSIT THE CHECK.** Please endorse the check on the back & forward the check with the explanation of benefits to the Physician who performed your procedure at their office.

LABORATORY CHARGES: Laboratory services are billed separately through ADH-Pathology Lab, Dianon,

ENDO-CDX and Genesis Laboratory.

I have read and understand the above information. I agree to the terms and conditions as noted above:

Patient Signature _____ Date _____

(REVISED: 08/27/2019) PATIENT LABEL