Gateway Medical

# Financial Policy

*We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.*

**AGREEMENT**
This is an agreement between Gateway Medical, LLC, as provider and creditor, and the patient named on this form. By executing this agreement, you, the patient, are agreeing to pay for all services that are received.

**MONTHLY STATEMENT**
If you have a balance on your account, we will mail you a monthly statement. All balances are expected to be paid in full upon receipt of this statement.

**INSURANCE**
We will bill your insurance(s), however, the insurance company will make the final determination of your eligibility for coverage. You agree to pay any portion of the charges not covered by insurance. This includes deductibles, co-pays, and co-insurance; as determined by your insurance company.

**DISPUTES**
You should notify our office immediately of any discrepancies. Please call our office or send us a message by visiting our website: https://www.gatewaycares.com/contact-us. We will investigate and resolve your dispute within 30 days.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Date