LifeBridge Community Gastroenterology  
Pikesville MD Endoscopy  
Glen Burnie MD Endoscopy

The Westminster Endoscopy ASC, LLC

**Notification of Financial Obligation and Promise to Pay**

Date: \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Account Balance: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copay: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Remaining Deductible Balance: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coinsurance: $ To Be Determined\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above financial information is an estimate of your cost for your upcoming scheduled procedure(s) as reported by your health insurance carrier. Your insurance carrier’s **Verification of Benefits and Coverage** is not a guarantee of payment. The amount may change depending on the processing of your claim by your insurance company.

You are financially responsible for paying the total amount owed for the service you received (copay, deductible, and coinsurance). You will receive a bill in the mail after your insurance has processed your claim and informed us of the patient responsibility.

Payment in full is expected within 30 days of your initial statement. Please call our billing department at 410-602-9343 if you need to set up a payment plan. Your account may be turned over to an outside collection agency if payment is not received.

Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship To Patient (if not patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

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