Atlantic Digestive SPECIALISTS
Helping people inside & out

ADVANCED GUARANTOR'S NOTICE WAIVER OF LIABILITY

FOR ALL INSURANCE PLANS *EXCEPT MEDICARE*

Patient's Insurance Company_____

X	21 Clark Way, Rte. 108	Somersworth, NH 03878
☐	330 Borthwick Avenue, Suite 300	Portsmouth, NH 03801

We believe, in your case, your Insurance plan may not cover the following service(s):

□ Office Visit □ Consult □ Breath Hydrogen □ Liver Biopsy
□Screening Colonoscopy □ Flexible Sigmoidoscopy □ EGD
□ Diagnostic Colonoscopy □ EUS □ ERCP □ PDT □ BRAVO □ H-Pylori
□ Other: _____

***Estimated* cost or price range of procedure(s): $ 695.00 - $ 1450.00**
Note: Estimate does not include hospital, pathology, and/or radiology charges or costs

Service may not be covered for one or more of the following reason(s):

Your insurance requires a referral be obtained prior to any specialist service(s). We have not received a referral to date from your PCP office.

Service and/or treatment considered a routine screening and may not be covered by your insurance plan. Contact your insurance carrier to verify your benefit coverage.

☐ **Insurance does not cover and/or allow benefits for this service.**

Please note that the estimate above applies to GASPA physician's charges only.
We are unable to quote and do not have any cost estimates for hospital, pathology, lab or radiology services..

Patient/Guarantor's Agreement

My physician has notified me that it is believed, in my case, my insurance plan *may* deny payment for the services identified above for the reason(s) stated. If my insurance plan denies payment, I agree to be personally and fully responsible for payment.

_____ _____
Patient / Guarantor's Signature **Date**

***(Print)* Patient Name:**_____

Date of Birth:_____

Form 707A

Form 707