Centers for Gastroenterology
Specialists in Digestive Health

FINANCIAL POLICY
(Effective December 2015)

The physician/patient relationship is a partnership based on mutual trust and confidence. The following is our financial policy. We hope this clarifies the terms of our financial relationship with you. Should you have any questions, please request to speak with a business department representative.

The Patient:

- **If you have Insurance, you must provide the office with the most current insurance information about your coverage**. The Centers for Gastroenterology will file an insurance claim on your behalf with your company of record. If insurance information has not been provided by you in a timely manner and charges are denied per your insurance guidelines for timely filing, then any balance will be the patient's responsibility. Co-payments, co-insurance and deductibles are the patient's responsibility and due at the time of service. It is also your responsibility to confirm your eligibility and benefits with your insurance company. Filing a claim with the insurance company is not required. If you choose not to file a claim, please inform us upon check-in or check out. If this is the case you will be required to pay for the visit in full at the time of service.
- **Will assist in the follow-up with your insurance company, if requested**.
- **Payment must be made at the time of service for any amounts that are not covered by your insurance including**, but not limited to, co-payments, deductible, and co-insurance. Any remaining balance after the insurance has paid is due and payable within thirty (30) days. Failure to pay this balance in sixty (60) days will result in immediate action, including, but not limited to reporting your actions to a collection agency and the national credit bureau wire agency and your insurance company. Further visits with the physicians of CFG will not be scheduled until payment requirements are met.
- **Must meet all payment plan requirements** should such a plan be authorized and implemented. Failure to do so will result in immediate action, including, but not limited to reporting your actions to a collection agency and the national credit bureau wire agency and your insurance company. Further visits with the physicians of CFG will not be scheduled until payment requirements are met. *I understand that should my account become delinquent and turned over to any attorney and/or collection agency, I will be responsible for all costs of collections, legal fees and attorney fees incurred as a result.*
- **Must provide proof of a current referral (Medicare does not require a referral)**. If your insurance requires you to have a referral for your visit with the Centers for Gastroenterology, your primary care physician is responsible for providing you and/or the Centers for Gastroenterology with a referral authorization number. Furthermore, I recognize that, if I do not have a copy of the referral form with me at this time or, the Centers for Gastroenterology has not received their copy yet, I have the following options:
  - I can call my primary care physician and request they fax a referral 970-207-1893 for this visit at the Centers for Gastroenterology;
  - I can reschedule this appointment and bring my copy of the referral form or the authorization number with me to that appointment;
  - I can keep this appointment today, without either of the above, and I understand that my insurance company may not pay for the charges related to my visit today. Additionally, I understand that I will be personally responsible for and must make payment in full for all charges related to my visit today at the conclusion of today's visit.
  - Furthermore, if it is determined after my visit that I should have had a referral and I didn't, I agree to be fully responsible for the charges related to my visit.
- **Is responsible for** notifying our office within two (2) business days to cancel an office appointment or within three (3) business days to cancel a scheduled procedure. A fee of $50 will be charged for office visit no shows or failure to cancel an office visit in 48 hours and a fee of $300 will be charged for no shows for scheduled procedures. Insurance will not cover these fees. If you fail to show up on your initial office visit, a deposit of $100 will be required before you will be rescheduled for your visit. The $100 will be applied towards any balance due to the Centers for Gastroenterology. Any amount remaining after the balance due is paid will be refunded to you. If you no show again, you will not be rescheduled.
- **Right to Restrict** I understand that if my medical or billing records contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, that I agree to its release to other healthcare professionals / facilities. I understand that I have the right to request a restriction on how my protected health information is used for treatment, payment, or healthcare operations. **The Centers for Gastroenterology is not required to agree to any restrictions, but if we do, we are bound by our agreement.** If you wish to make a restriction please request a copy of our form to request restrictions.

➡ Would you prefer that we contact you through My Health Connect **YES ( ) NO ( )**

➡ Please leave us a confidential phone number in case we cannot reach you via the Patient Portal: ___________________________________

➡ Who are we authorized to speak with, ***other than you or your doctor***? ____

By signing below I agree that:

- I have read, understand and agree to the terms of the above policy statement.
- I understand that I am financially responsible to the Centers for Gastroenterology for any charges not covered by my insurance.
- I authorize the Centers to release any medical information necessary to process my medical insurance claims.
- I hereby assign all insurance payments for which I am entitled for medical or surgical services to the Centers for Gastroenterology.
- **I authorize the Centers for Gastroenterology** to release all of my labs, procedures, and test results to me.

____ _______________________________
Signature **Date**

____ _______________________________
Print Name **DOB**

I understand if my medical or billing records contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release to other healthcare professionals / facilities. I understand that I have the right to request a restriction on how my protected health information is used for treatment, payment, or healthcare operations. We are not required to agree to any restrictions, but if we do, we are bound by our agreement. If you wish to make a restriction, please request a copy of our form to request restrictions.

I acknowledge receiving a copy of the HIPAA Privacy Practice Notice.

____ _______________________________
Signature **Date**

This form may be returned to Harmony Surgery Center, Skyline Endoscopy or Estes Park Medical at the time of your procedure