

Gastroenterology Specialists of Oregon, PC The Gastroenterology Endoscopy Center, Inc

Financial Policy

It is the policy of Gastroenterology Specialists of Oregon, PC (GSO) and The Gastroenterology Endoscopy Center, Inc is to have a Financial Policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and also minimizing administrative costs. This Financial Policy has been established with these objectives in mind, and to avoid any misunderstanding or disagreement concerning payment for professional services.

- New patients will be required to pay a deposit up to or equal to their deductible and co-insurance responsibility. This deposit will be applied towards the fees we charge the patient for our services. The exception will be on our contracted co-payment plans. We do require that you satisfy any co-payment at the time of your visit.
- Our Endoscopy Ambulatory Surgery Center participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our business office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance that we do not participate in, our office is happy to file the claim upon request; **however, payment in full is expected at time of service.**
- Payment for professional services can be made with cash, check or accepted credit card.
- If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is your responsibility to inform us prior to the visit.
- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be asked to sign a disclaimer indicating you will be financially responsible due to lack of the referral.
- It is the patient's responsibility to provide us with current insurance information and to bring their insurance card to each visit.
- Our billing office is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company's Member Services Department. (The phone number is usually listed on the insurance card.)
- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of service. For unaccompanied minors, non-emergent treatment will be denied unless charges have been pre-authorized or payment by credit card, cash or check at time of service has been verified.
- Effective in 2009, we will request only the last four digits of a patient's Social Security Number to assist with patient identification within our office. Only the last four digits are used because protection of your personal identity is important to us.
- For all unpaid balances over 90 days, the Endoscopy Center and/or GSO will apply FINANCE CHARGES at 1.5% per billing cycle (which equates to a 18% ANNUAL PERCENTAGE RATE). Unpaid balances are determined at the closing of your most recent account statement. All monies credited to your account prior to and including the statement closing date shall reduce your unpaid balance accordingly. The figure remaining after crediting all account payments is your unpaid balance, and finance charges shall be assessed against that figure as provided in this policy.

Signature of Patient or Responsibility Party

Date

**Gastroenterology Specialists of Oregon, PC
The Gastroenterology Endoscopy Center, Inc**

BILLING RIGHTS SUMMARY

In Case of Errors or Questions About Your Bill

If you think your bill is wrong, or if you need more information about a transaction on your bill, write us at 1508 Division Street, Suite 15, Oregon City, OR 97045, as soon as possible. We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared. You can telephone us, but doing so will not preserve your rights.

In your letter, please give us the following information:

1. Your name and account number.
2. The dollar amount of the suspected error.
3. Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item you are unsure about.

You do not have to pay any amount in question while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. While we investigate your question, we cannot report you as delinquent or take any action to collect the amount you question.

Special Rule for Credit Card Purchases

If you have a problem with the quality of goods or services that you purchased with a credit card, and you have tried in good faith to correct the problem with the merchant, you may not have to pay the remaining amount due on the goods or services. You have this protection only when the purchase price was more than \$50 and the purchase was made in your home state or within 100 miles of your mailing address.

Non-Sufficient Funds Payments

A service charge of \$25.00 will be assessed for all checks returned by your bank for non-sufficient funds or written on a closed account.

Cancellation Policy

I understand that if I want to cancel a **procedure** I must do so two working days prior, Monday through Friday. I understand I will be charged a **\$100.00** late cancellation fee if I fail to do so. This will be waived if one of our physicians determines that the procedure needed to be cancelled.

Refund Statement

Credit balances less than \$10.00 will be refunded by request only.

Authorization of Claims Information

I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I authorize my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents. I authorize the insurance(s) and other payers, whose information I have provided, to pay and hereby assign directly to Gastroenterology Specialists of Oregon, PC and/or The Gastroenterology Endoscopy Center, Inc all benefits, if any otherwise payable to me for his/her services.

We are here to help you. Please sign that you have read and agree to this Financial Policy.

Signature of Patient or Responsible Party

Date