

# Gastroenterology Associates

Gastroenterology and Hepatology

olygastro.com

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## FINANCIAL RESPONSIBILITY

It is your responsibility to confirm your insurance benefits with your insurance carrier prior to your appointment. We participate in most insurance plans, including Medicare. We will bill most insurance companies directly as a courtesy to you. You are responsible to verify your benefits for all services provided. If you receive non-covered services or we are non-participating providers in your plan, you will be responsible for any charges. If a referral or authorization is needed, check with your insurance to make sure it is in place prior to your appointment.

**To protect your identity we require identification and proof of insurance at each visit.** If your insurance has recently changed, please notify us when you check in for your appointment.

**Your co-payment is due upon check in for your appointment.**

### **PLEASE READ - IMPORTANT INFORMATION REGARDING COLONOSCOPY APPOINTMENTS**

*Insurance benefits vary based upon the type of colonoscopy performed.  
Please contact your insurance company directly to verify your coverage.*

A screening colonoscopy is a procedure provided to the patient in the absence of signs and symptoms and no prior colorectal polyps for the purpose of testing for the presence of colorectal cancer or colorectal polyps.

A diagnostic colonoscopy is a procedure provided to the patient as a result of a sign, symptom or abnormal finding, such as history of colorectal polyps, blood in the stool, changes in bowel movements, diarrhea, constipation, etc.

Once your insurance has processed your claim, a statement will be sent to you for any remaining patient responsibility amounts. Payment is due in full within 16 days from the date the statement is mailed. If your account is not paid timely and it is necessary to send to a third party for collections, you will not be able to schedule further appointments until you have made payment arrangements and make your first payment. A \$25.00 charge will be added for any NSF or returned checks from your bank.

**You may contact our office to pay your bill by credit card 360-413-8250.**

Each procedure may generate several separate service statements including:

*Physician Fee*

*Facility Fee*

*Anesthesia Provider Fee*

*Pathology Technical and Read (Pathologist) Fees (if biopsies are taken)*

### **ASSIGNMENT OF BENEFITS**

I have reviewed and verified my demographic information for this visit. I hereby assign all medical and surgical benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, or third-party insurance to issue payment directly to Gastroenterology Associates and/or Gastroenterology Associates Endoscopy Center for medical services rendered to myself regardless of my insurance benefits, if any. I understand that I am responsible for any patient responsibility not covered by my insurance.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please call our Patient Services Specialists at 1-855-543-6294 if you have questions. We will be happy to assist you.**