NW Gastro | Endo

PATIENT CARE AGREEMENT

We have established a Patient Care Agreement to avoid misunderstandings. Please read the policy carefully. If you have any questions a member of our staff will be happy to discuss the policy with you.

- We bill all major commercial insurance companies, Medicare, DSHS, L&I, and Tricare.
- We are unable to bill your insurance until we obtain a copy of your card. Without the card or a copy on file you may be responsible for the bill.
- If you do not have insurance, payment is expected at the time of service. We recognize that there may be times when full payment is not possible. Please contact our billing department at 360-734-1420 option 5 to set up a payment plan.
- **CO-PAYS ARE DUE AT THE TIME OF SERVICE.** The co-pay is an agreement made between the subscriber and the insurance company.
- We cannot accept responsibility for a disputed claim. If your insurance company denies the claim or withholds payment, you are ultimately responsible for the balance due.

- **PATIENT RESPONSIBILITIES**

    1. Patient agrees to provide our office with a current copy of insurance card. This includes information on secondary and tertiary plans.
    2. Patient agrees to pay co-pays on day of service.
    3. Patient agrees that if their insurance plan requires a referral from their primary care physician, it will be their responsibility to obtain the referral.
    4. Patient agrees to provide NW Gastroenterology/Endoscopy with updated information, home address and telephone numbers. For patients not living in the United States, patient agrees to provide and/or maintain an address in the United States.
    5. Patient agrees to pay any balance due within 30 days of receipt
    6. Patients who cancel their appointment without minimum notice (48 hours) risk being removed from our practice.
    7. Patients who no-show for their appointment and/or procedure will be charged a no-show fee.
        - All Endoscopic Procedures - $250.00
        - All Office Visits - $100.00
    8. Patients who arrive 10 or more minutes late for their appointment may be rescheduled.
    9. Patient with unpaid accounts and/or accounts sent to collections may be removed from our practice.
    10. Patients who are not compliant and/or do not follow recommended treatment plan by our physicians may be removed from our practice.
    11. Patient agrees that if an e-mail address is provided, patient will be responsible to notify us of any e-mail address change.
    12. Patient assumes responsibility for e-mail access and acknowledges that our office cannot be responsible for any family members and/or friends who may access your information.
- NW Gastroenterology & Endoscopy will make every effort to work with you to arrange satisfactory payment of your bill. If however, payment is not received within 90 days of service and you have not contacted this office to arrange a payment plan, collection activities will commence. NW Gastroenterology & Endoscopy utilizes the services of an outside collection agency.

RELEASE OF BENEFITS AND INFORMATION: I authorize the physician or insurance company to release any information for my claims. I authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I understand that NW Gastroenterology will not bill my insurance unless I provide them with a current copy of my insurance card and that unless I do so I am solely responsible for my entire bill. I authorize the use of SMS messaging containing payment information. I may opt out by contacting the billing department.

I have read and understand the Patient Care Agreement as noted above.

______________________________ ______________
Signature of Patient Date

______________________________ ______________
Printed Name Date of Birth

4.1.26