NW Gastro | Endo

PATIENT INFORMATION **MRN** _____

Last Name _____ First Name_____ Middle Initial_____

Birthdate _____/_____/_____ Sex: Male Female Other Social Security Number _____

Mailing Address _____ Apt/Ste# _____

City _____ State _____ Zip _____ E-Mail _____

Preferred Phone _____ Alt. Phone _____

Primary Care Physician Name & Location_____

ALLOWING ACCESS TO YOUR MEDICAL INFORMATION

I consent to allow secure access to my Electronic Health Record to the following people: (Does not include medical professionals involved in your coordination of care). Communication may include phone access, delivering lab results verbally or in person, discussing my medical condition, pick up copies of electronic medical record, and/or my appointment information. (This information will remain current unless you alert us of a change)

_____ _____ _____ _____

_____ _____ _____ _____

Name Relationship Phone Date

I consent to allow providers and staff at NWGI/NWEC to leave a detailed message at the following phone number and/or email. I understand this may include information regarding appointments as well as personal medical or financial information related to my medical care.

Phone Number where messages can be left _____ E-Mail _____ Date _____

INSURANCE

Primary _____ ID # _____ Secondary _____ ID # _____

Responsible Party Information (complete if patient under 18 OR spouse or parent provides insurance)

Last Name _____ First Name _____Middle Initial _____ DOB _____

Address _____ APT/STE# _____ City_____ State _____ Zip_____

Preferred Phone _____Alt. Phone_____ Employer _____

Relationship to patient _____

If we are billing an insurance carrier the printed name on the card must match EXACTLY to what is above.

Patient Signature _____ **Date**_____

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.
   - Procedure or New Patient Office Visit - $50.00
   - Established Patient Office Visit - $25.00
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 have read and understand the Patient Care Agreement as noted above.

_____ _____

Signature of Patient Date

_____ _____

Printed Name Date of Birth

12.10.21