Greater Houston Gastroenterology, PLLC

FINANCIAL POLICY

Welcome to Greater Houston Gastroenterology, PLLC (GHG) and thank you for choosing us! We appreciate your confidence and goodwill. To ensure that we have financial stability and can continue to provide medical services to the community and region, the following policies shall be enforced:

Self Pay/Non-Contracted Plans:

- All charges are due and payable at time of service. We accept cash, checks, and major credit cards. We may reschedule the appointment if payment is not made prior to the services rendered.

Patients with insurance:

- GHG will submit a claim for the current services to your insurance carrier. Insurance carriers are required to pay their portion of the claim within 45 days of receipt. When an insurance carrier is required to pay GHG for a service that has been provided, you are only responsible for what is considered the patient portion of the claim. However, if your insurance carrier rejects, delays, withholds, denies payment of its portion or covers only a portion of treatment for more than 90 days from the date of service, both the insurance and patient portions of your account then become your responsibility. If we subsequently receive payment from your insurance carrier, we will credit your account for the amount of the payment.
- It is the patient's responsibility to determine whether a referral is required, and the referral can be requested from your primary care physician. If you do not obtain a referral from your primary care physician prior to receiving services or a referral cannot be verified by our office, you have the option of re-scheduling your appointment. If you keep your appointment and/or receive services in our office, it is with the understanding that your health plan may not pay for charges related to the services provided by Greater Houston Gastroenterology, PLLC and that without a referral you will be responsible for payment of all charges.
- Pre-existing clause: If the patient has a current pre-existing clause in the policy, the patient is required to pay the full charge for the service being rendered instead of patient's copay.

No-Show and Cancellation Policy:

- If the patient fails to cancel his/her office appointment at least 24 hours in advance, the patient is responsible for $45 fee which will not be applied to any copay, deductible or coinsurance. For a procedure, the patient must cancel at least 48 hours in advance or is responsible for $100 fee with same conditions.

Delinquent / Unpaid Account:

- Prior to providing services, payment of prior outstanding accounts will be requested and should be received. Patients with unpaid delinquent accounts or accounts which have been written off to bad debt may be denied treatment if not medically urgent.
- Accounts which cannot be collected by the physician after normal in-house collection procedures may be referred to a collection agency, magistrate, or attorney for further collection action in accordance with the physician's established guidelines. Changes shown by statements are agreed to be correct and reasonable unless protested in writing within (30) thirty days of billing.

Refunds:

- Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients' refunds will not be processed until all active or past due accounts are paid in full.

Third Party Litigation:

- Our physician will not become involved in disputes arising from third party claims (i.e. automobile accidents, liability claims, etc.)

Insurance / Disability forms:

- There will be a $25 handling fee to cover the administrative fee for writing a letter or filling out claims forms, such as insurance forms and disability forms (except Medicare patients). The fee is due once the form is completed, and the patient will be directly responsible for this fee.

Returned Checks:

- Checks returned to Greater Houston Gastroenterology, PLLC for insufficient funds, closed account, stopped payment, or for any other reason will be subject to $50.00 fee.

Medical Record:

- A reasonable fee of $25.00 shall be charged for the first twenty pages and $0.50 per page for every copy thereafter. Requests will be completed within ten (10) business days.

I, the patient/patient's legal representative, understand and agree to abide by the financial policy set forth.

______________________________	______________________________	__________
Printed Name	**Signature of Patient (or Personal Representative)**	**Date**

Patient Demographic Information

Greater Houston Gastroenterology

PATIENT NAME (First Name, Middle Initial, Last Name)	DATE OF BIRTH AGE	PRIMARY PHONE (HOME)	SECONDARY PHONE (WORK /CELL)
ADDRESS	SOCIAL SECURITY NUMBER	SEX (M or F)	MARITAL STATUS
CITY, STATE, ZIP	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER NAME & ADDRESS	OCCUPATION	E-MAIL ADDRESS	
RACE	ETHNICITY PLEASE CIRCLE: HISPANIC/PATINO OR NOT HISPANIC / LATINO	LANGUAGE	
HOW DID YOU HEAR ABOUT US			

REFERRING DOCTOR NAME, ADDRESS & TELEPHONE NO.

PRIMARY CARE DOCTOR NAME, ADDRESS & TELEPHONE NO.

Pharmacy

PHARMACY NAME & ADDRESS	TELEPHONE

Primary Insurance (please attach insurance card)

(If you have Medicare and other insurance, please refer to Medicare website for reference)

INSURED'S NAME (First Name, Middle Initial, Last Name) INSURANCE MEMBER SERVICE TELEPHONE NO.	INSURED'S HOME PHONE	INSURED'S WORK / CELL PHONE NO.
INSURED'S ADDRESS	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NO.
INSURED'S CITY, STATE, ZIP	INSURED'S SEX (M or F)	INSURED'S RELATION TO PATIENT
INSURED'S EMPLOYER	INSURED'S OCCUPATION	
INSURANCE COMPANY NAME	INSURED'S ID #	
INSURANCE COMPANY ADDRESS	INSURED'S GROUP #	
INSURANCE COMPANY CITY, STATE, ZIP	INSURANCE COPAY AMOUNT	

Secondary Insurance (please attach insurance card)

INSURED'S NAME (First Name, Middle Initial, Last Name) INSURANCE MEMBER SERVICE TELEPHONE NO.	INSURED'S HOME PHONE	INSURED'S WORK / CELL PHONE NO.
INSURED'S ADDRESS	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NO.
INSURED'S CITY, STATE, ZIP	INSURED'S SEX (M or F)	INSURED'S RELATION TO PATIENT
INSURED'S EMPLOYER	INSURED'S OCCUPATION	
INSURANCE COMPANY NAME	INSURED'S ID #	
INSURANCE COMPANY ADDRESS	INSURED'S GROUP #	
INSURANCE COMPANY CITY, STATE, ZIP	INSURANCE COPAY AMOUNT	

Authorization and Acknowledgement

AUTHORIZATION: I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed. ____________ Initials

ASSIGNMENT OF BENEFITS STATEMENT: I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred. ____________ Initials

ACKNOWLEDGMENT OR RECEIPT OF PRIVACY NOTICE: I hereby acknowledge receipt of the Notice of Privacy Practices (attached) given to me by the above company. ____________ Initials [ ] Consent refused by patient. Witness by: ____________________

____ Printed Name

____ Signature of Patient (or Personal Representative)

____________________ Date

Greater Houston Gastroenterology, PLLC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

ATTENTION: It is the patient's responsibility to obtain any medical records prior to the appointment. Patients may use this form to obtain patient medical information from any physician offices, hospitals or other healthcare facilities where they require patient written authorization.

Patient Name: ______________________________ Date of Birth: ______________ SS No: _______________

Address: ____

I hereby authorize ____(Doctor Name/Facility Name),

Tel: #_________________________, Fax #: ___________________________ to release the following medical information to:

Greater Houston Gastroenterology, PLLC

Check all that may be released:

[ ] Complete record

[ ] Records of care from ____________________ to ___________________

[ ] Records of care concerning the following condition(s): ________________________.

[ ] Other. Specify: _________________________.

[ ] Please exclude the following specified information: ___________________________.

Purpose of disclosure:

[ ] Medical Care [ ] Insurance [ ] Legal [ ] Other: ___________

The authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above name facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

____ ________________________

Patient or Representative Signature Date

____

Relationship or status if signed by anyone other than patient

Greater Houston Gastroenterology, PLLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO INDVIDUALS

I authorize Greater Houston Gastroenterology, PLLC (GHG) to disclose and release medical or other information to the below listed individuals. I understand that this includes, but is not limited to information related to treatment, diagnosis, billing or any health care operations performed at this facility.

____________________	____________________	____________________
Name	**Relationship**	**Phone Number**
____________________	____________________	____________________
Name	**Relationship**	**Phone Number**
____________________	____________________	____________________
Name	**Relationship**	**Phone Number**

I understand that all information requested will be provided to these individuals and I release GHG from all liability pertaining to the release of this information. I understand that this request can be changed at any time through a signed written request.

____________________	____________________	____________________
Printed Name	**Signature**	**Date**

SCREENING COLONOSCOPY

(Please sign this form if you may need to schedule a screening colonoscopy)

Patients who have screening examinations have no signs or symptoms, and have a set benefit from their insurance company. You need to be informed that if the physician performing your procedure finds a polyp or abnormality, your benefits may change and your insurance policy will pay differently. The colonoscopy is no longer considered a screening procedure, it is considered a surgical procedure.

I acknowledge that I have read the above statement and will be responsible for my deductible, co-pay and out-of-pocket expenses in the event that my scheduled screening examination does result in a procedure with a polyp or abnormality.

____________________	____________________	____________________
Printed Name	**Signature**	**Date**