



## PATIENT FINANCIAL POLICY

Thank you for choosing Eugene Gastroenterology Consultants as your digestive health care provider. We are committed to building a successful physician-patient relationship. Your clear understanding of our Patient Financial Policy is important to our professional relationship and payment for services is a part of that relationship. Please contact our Patient Financial Services (PFS) department if you have any questions about our fees, our policies, or your responsibilities. **PFS: 541-868-9502.**

### PROFESSIONAL AND FACILITY FEES

If you have a procedure at the Oregon Endoscopy Center or Sacred Heart Medical Center at River Bend you will be receiving a separate bill from them for the facility fee. Your bill from EGC represents the physician's fees only. Fees for services are available upon request.

### CANCELED APPOINTMENTS

We require forty eight (48) hour notice for canceling or rescheduling your office appointment and seventy two (72) hour notice for canceling or rescheduling your procedure. An administrative fee of \$25 will be imposed for failing to provide adequate notice for an office visit. Procedure appointments that are not canceled within the required notice of 72 hours will be assessed a fee of \$100. The fee for failing to show for a procedure appointment is \$100. Please refer to the *Missed Appointments Policy* for more information.

### COPAYS

Please bring your most current insurance cards with you to your visit. **All copayments and past due balances are due at the time of check-in.** Unless prior arrangements have been made, an additional fee of \$25 may be imposed for copays that are not paid at the time of service.

### INSURANCE

It is very important to provide our office with accurate, up to date, insurance information. Insurance coverage is an agreement between you and your insurance carrier. The amounts they pay toward your medical care depend upon your individual policy. Our office is not responsible for collecting insurance monies or negotiating a settlement on a disputed claim. **It is your responsibility to check your policy and contact your insurance company for questions regarding your coverage.**

We are participating providers with most insurance carriers, including Medicare, and as a courtesy to you we will bill most primary and secondary insurances. You will be responsible for any deductibles that have not yet been met as well as any service that is denied or not covered. Many patients are enrolled in managed care products. In order for us to obtain referrals and/or pre-authorizations for procedures, it is very important that we have your most current information.

### RETURNED CHECKS & REFUNDS

Your account will be charged a service fee of \$35.00 for each check returned by the bank. No refunds will be issued on your account for less than \$5.00.

### DEPOSITS REQUIRED AND PAYMENT PLAN OPTIONS

All accounts are due in full upon receipt of your first statement. We do however understand that financial circumstances vary from patient to patient and therefore will strive to find an option for payment that works for both of us. By extending this courtesy, we ask the following from you:

1. Automatic recurring payments be set up on ALL accounts that require a payment plan.
2. Keep your account current and follow the terms of any agreed upon payment plan.
3. Contact our Patient Financial Services department if you are having trouble keeping your account current.

If we have not received a payment or heard from you within 45 days of your statement going out, your account will be considered delinquent and will be forwarded to our Business Manager for review and possible collection action.

***Deposits Required: Patients with Medicare or OHP insurances and patients having a screening colonoscopy are excluded. A \$250.00 deposit is required to be paid 2 weeks prior to your scheduled procedure. Nonpayment will result in your procedure needing to be canceled or rescheduled. This applies to procedures only, office visits do not require a deposit if active insurance is provided.***

Prior to scheduling your appointment, you will be asked to provide credit/debit card info in order to set up an automatic recurring payment that will start approximately 60 days following the date payment was arranged. This payment will be based on your estimated costs minus your deposit. This is only an estimate and therefore may need to be adjusted after the procedure is completed and your insurance has been billed. It is your responsibility to contact us to adjust payments accordingly. In the event that your account gets assigned to a collection agency, our office charges an administrative fee of \$150 per account and you may be terminated from our practice.

### ADDITIONAL INFORMATION FOR SELF PAY PATIENTS

If an insurance company will not be billed, a deposit is required 2 weeks prior to your visit. If the deposit is not received within the timeframe requested, your appointment **will be canceled.**

**Office Visit Deposit: \$150**

**Procedure Deposit: 50% of the base procedure fee**

### PATIENT FINANCIAL AGREEMENT

All fees are subject to change without notice at the discretion of Eugene Gastroenterology Consultants, P.C. I understand and agree that regardless of my insurance status, **I am ultimately responsible for the balance on my account for any professional services rendered.** I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date