Patient:	Patient Test		
MRN:	000000000		
DOB:	1/1/1965	**Procedure:**	Colonoscopy
Gender:	Male	**Date:**	8/23/2023
Age:	58 year(s)	**Attending Physician:**	Test, Doctor

Front Desk: AD, Finance, Privacy Consent

Oregon Endoscopy Center, L.L.C
3355 RiverBend Drive, Suite 510 Springfield, OR 97477-8800 | 541-868-9555

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ADVANCE DIRECTIVE POLICY

In Oregon, the Health Care Decisions Act (ORS127.5056-127.660 and ORS 127.995) allows individuals to preauthorize health care representatives to allow the natural dying process if they are medically confirmed to be in one of the conditions described in their healthcare instructions. This Act does not authorize euthanasia, assisted suicide, or any overt action to end a person's life.

Oregon Endoscopy Center respects and honors all patient's right to participate in their own healthcare decisions. Patients may formulate Advance Directives or execute Powers of Attorney authorizing others to make decisions on their behalf based on the patient's expressed wishes when the patient cannot make or communicate decisions. If a patient should provide their Advance Directive, a copy will be placed in the patient's medical record and transferred with the patient should a hospital transfer be ordered by their physician.

Oregon Endoscopy Center recognizes that members of the Medical Staff have the primary responsibility for discussing an Advance Directive with patients. In addition, the Medical Staff's responsibility is to provide information and education to enable individuals to make decisions regarding their Advance Directive in a thoughtful and informed manner.

While a patient at the Oregon Endoscopy Center, you can expect that every effort will be made to resuscitate you in the event of an emergent situation fully.

Endoscopic procedures typically utilize sedatives for temporary alteration in consciousness to allow the performance of procedures with comfort and safety. Side effects may include low blood pressure (hypotension), and a decrease in oxygen levels due to inadequate breathing (respiratory depression). The effects of sedatives can be very rapidly reversed using medications given through an IV. Therefore, in the uncommon situation where too much sedation is provided, resulting in these very temporary side effects, reversal agents may be provided to counteract the sedatives.

If you have any questions or concerns regarding this policy, please feel free to contact your physician before your procedure appointment at the number listed above.

I acknowledge receipt of this notification.

PATIENT FINANCIAL POLICY

SEPARATE BILLINGS

Facility Fee: Oregon Endoscopy Center, L.L.C. will submit a charge for the facility fee. This charge covers the use of the procedure and recovery rooms, sedation, equipment, supplies and medications necessary to perform your procedure. It also covers the services of the

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clinical staff.

Physician Fee: Eugene Gastroenterology Consultants, P.C. will submit a charge for your physician's fee. This is what your physician charges for performing your procedure.

Pathology Fees: If pathology is sent to the laboratory, there will be separate bills for preparation and interpretation of the specimen.

Anesthesia Fee: If Anesthesia is performed, it will be provided by Anesthesia NW. They will submit all charges for anesthesia services. Patient responsibility will not exceed $275.

Both you and your insurance carrier will receive a separate bill for each of these services. Your physicians' office and the facility are two separate entities and are required to bill separately for these services. Regardless of where you have your procedure performed, you will receive two separate bills. (This billing method is standard and required by all insurance carriers)

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. In order to for us to obtain referrals and/or pre-authorizations, 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 insurance 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 could result in your procedure needing to be canceled or rescheduled.

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 30 days following your procedure on the date payment was arranged (you will be given options on which day of the month works best). This payment will be based on your estimated costs minus your deposit. This is only an estimate and therefore may need

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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.

SELF PAY
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.**

Procedure Deposit: 50% of the base procedure fee

**Deposits may be subject to change. All other information in the Deposits Required and Payment Plans section above apply

Fees for services are available upon request. Please call our Patient Financial Services (PFS) department if you have any questions.

Oregon Endoscopy Center is owned by the physicians of Eugene Gastroenterology Consultants, P.C.

PATIENT FINANCIAL AGREEMENT
All fees are subject to change without notice at the discretion of Oregon Endoscopy Center, LLC. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A **NOTICE OF PRIVACY PRACTICES** is provided to all patients on their first visit. This Notice of Privacy Practices identifies how medical information about you may be used or disclosed. It explains your rights to access your medical information; to request an accounting of disclosures of your medical information and to request addition restrictions on our uses and disclosures of that information. It explains your rights to complain if you believe your privacy rights have been violated, and our responsibilities for maintain the privacy of your medical information, and letting you know if that privacy is breached.

The undersigned has received a copy of the NOTICE OF PRIVACY PRACTICES and is the patient or the patient's personal representative.

Additional Questions

Variations to any of the above:

Signatures

Patient or Legal Guardian Signature
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