DEPARTMENTS OF GASTROENTEROLOGY AND ENDOSCOPY

FINANCIAL POLICY

Thank you for choosing WWMG Departments of Gastroenterology and Endoscopy to meet your specialized medical needs. We are committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, of which we require that you read and sign.

All patients must complete our Patient Registration form on an annual basis, as well as completing our Financial Policy prior to seeing the physician.

IF YOU ARE NOT COVERED BY INSURANCE, PAYMENT IN FULL,
IS DUE AT THE TIME OF SERVICE

FOR YOUR CONVENIENCE WE ACCEPT CASH, CHECKS, VISA & MASTERCARD

PAYMENT PLANS ARE ACCEPTED UPON APPROVAL

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you, as long as you provide us with the correct information. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered medically necessary under your health insurance plan. You, as the patient, ultimately are responsible for payment of all services provided by our Care Center. While payment is your responsibility, we will assist you in negotiating a settlement with your insurance company for any disputed claim. Our Patient Accounts department is available to discuss any questions you may have regarding your insurance or your account at (425) 259-0832.

Regarding insurance plans where we are a participating or preferred provider, all co-payments are due prior to treatment. In the event that you're insurance coverage changes to a plan where we are not participating or preferred providers refer to the above paragraph.

If you have a secondary insurance, we will bill it one time only for you, as a courtesy, as long as you have provided us with the appropriate information. You will be responsible to re-bill this secondary insurance if that becomes necessary. If you bill any insurance yourself, please do so promptly, so that you will receive reimbursement before your account is considered delinquent.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MEDICALLY NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. Therefore if your insurance company arbitrarily determines that a service we have rendered to you is unnecessary, you will be responsible for the bill. This may apply to some screening procedures. It is the patient's responsibility to determine whether or not your insurance will cover these screening diagnostic tests. We will be happy to provide the appropriate procedure and diagnostic codes to give to your insurance carrier, in order for them to determine coverage.

REFERRALS: It is your responsibility to obtain the appropriate referral from your primary care physician. We will assist you with this if necessary; however, your appointment may have to be rescheduled if the appropriate referrals are not in place on the date of your appointment.

NSF FEES/NO SHOWS/CANCELLATIONS: If a patient writes an NSF check (non-sufficient funds) or issues a stop payment, an administrative fee of $50.00 will be added to the patient's account per RCW 62A3. 515 & 520. Because of the time allotted for each patient visit, those individuals who do not keep their appointments or who do not cancel five (5) working days in advance will be subject to a no-show fee, and may not be allowed to reschedule the appointment. The length of time allotted for your scheduled appointment will determine your "no-show" fee. In personal injury cases (excluding L&I), a no-show charge of up to the amount of services billed, had they been rendered, may be billed for missed appointments, at the discretion of the PROVIDER. PROVIDER'S staff *may* not reschedule any patient that has missed an appointment.

The patient agrees that any deposition office conference, telephone consultation, or other contact by a representative of the PROVIDER with any attorney or insurance company acting or not acting on behalf of the patient will be charged at the customary and usual fee of PROVIDER, in addition to the expert witness fees charged by PROVIDER.

Failure to obtain a legal settlement sufficient to cover the costs of medical care and other specified fees and interest does not negate the patient's responsibility to pay these fees. When a claim is settled, dismissed, or discharged against a third party (at-fault party), all fees and have not been paid are considered the patient's responsibility and are immediately due and payable.

Office fees, no-show fees, billing notices, NSF check fees, etc. are subject to change at the discretion of PROVIDER. By signing this agreement, it is understood that you, the undersigned, or the guardian of the minor understands and agrees to abide by our Insurance and Payment policy and will accept the conditions thereof. By signing this contract, the undersigned patient, guarantor or legal guardian acknowledges that this contract replaces and supercedes all other previously signed contracts at PROVIDER for medical care.

CREDIT POLICY: Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 60 days.

We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our Patient Accounts department as soon as possible by calling (425) 259-0832.

If an account becomes past due with no valid reason, necessary action will be taken to recover the account balance due.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X____ Date:____________________

Signature of Patient or Responsible Party

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Please PRINT name