CONSENT AND RELEASE

1. The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

2. Patient or legal custodian authorized the Staff Physician (s) or Nurse Practitioner to examine and treat the above patient.

3. Westside Gastroenterology is granted permission to release to the insurance carriers, referring physician and primary care physician any information deemed necessary, as may be requested, relating to any treatment rendered to patient.

4. Patient or legal custodian shall agree to pay to Westside Gastroenterology such sums as are, or may become, due for services rendered to the patient.

5. ALL COPAYS AND DEDUCTIBLE ARE DUE AT THE TIME OF SERVICE INCLUDING ANY OUTSTANDING BALANCES.

6. In the event that the patient's insurance company does not make full payment on this obligation, all balances will be due and immediately payable by the patient and/or legal custodian.

7. A returned check fee of $30 will be assessed on any and all returned checks.

8. Delinquent accounts will be assessed all collection, legal, and administrative costs to the fullest extent of the law.

9. Patient or legal custodian understands that if their insurance company requires that a referral be issued, it must be received at time of service. If seen without a valid referral the patient accepts responsibility for full payment at the time of service with understanding that no claim will be filed with the insurance carrier.

Our fees for surgical procedures will vary depending on the service provided. We will ask for the patient's portion of the surgical bill at the time of the surgery (outstanding deductible and /or copay). You will receive separate bills from the surgery facility, lab, etc.

INSURANCE PAYMENT PLAN

We will file insurance with your provider according to your individual plan. The patient will be responsible for any outstanding deductible, their % and / or co-pay. Referral numbers required by some insurance companies must be given at the time of service, otherwise the service becomes the patient's responsibility. For all private insurance companies, the patient will be responsible for payment at time of service. We will provide the necessary information for the patient to file for reimbursement.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, otherwise payable to me for services as described, realizing that I am responsible to pay non-covered services.
SIGNATURE_____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.
SIGNATURE_____ DATE _____

PLEASE INITIAL EACH LINE ACKNOWLEDGING THAT YOU HAVE READ AND WILL COMPLY WITH OUR OFFICE POLICIES.

_____ All fees including copays, coinsurance, deductibles, and balances are due at the time of service.

_____ It is the patient's responsibility to notify the office of any changes to your insurance, address, or contact information .

_____ If refills are needed, an appointment is required. Please do not wait until you are out of medication

_____ Test results including: labs, pathology, radiology, stool studies etc. require at least **3-4 business days** to be obtained and released by the provider.

_____ Messages left for the provider and /or nurses will be addressed and returned within 48 hours. If you have left a previous message, please wait the allowed time before you call again.

_____ _____

Patient Signature **Date**