GASTROENTEROLOGY CENTER

Mike Bismar, MD, FACG, FASGE

Gastroenterology & Endoscopy

11797 South Freeway • Suite 140 • Burleson, TX 76028
Phone (817) 551-6161
Fax (817) 551-6177
www.gastro.center

Patient Welcome Packet

Dear Patient:
We want to express our appreciation to you for selecting our practice. We want your experience with us to be positive. We know filling out these forms can be difficult; your accurate responses will give us better understanding of your health problem. This enables us to provide you with the best possible medical care.

Your appointment location: **Gastroenterology Center**
Medical Office Building 3
11797 South Fwy, Suite 136
Burleson, TX 76028

To expedite your visit please fill out the enclosed forms, every form requires a signature on its own as it represent a separate legal document.

Remember to bring your:

1. Health insurance card.
2. Driver's License or government produced picture ID.
3. List of your medications along with dosages.
4. Co-payment / coinsurance if applicable (can be obtained from your insurance company)
5. Your deductible, if applicable, will be collected prior to your procedure

If you had previous upper endoscopy (EGD), colonoscopy, any other procedure, related x-ray, CT-scan, test or lab works, please contact our office, as early as possible, **before** your scheduled visit so we can obtain your medical records and findings ahead of time rather than during your visit. Obtaining your records from other providers may take 1 to 2 hours and sometimes a day or two.

If you have any questions, please contact our office at **817-551-6161** during business hours. Thank you and we look forward to seeing you at your appointment.

Business Hours: Monday to Thursday 8:30am – 12:00pm & 1:00pm – 5:30pm, Friday 8:30am – 12:00pm

Sincerely,

Staff of the Gastroenterology Center

Mike Bismar, MD, FACG, FASGE

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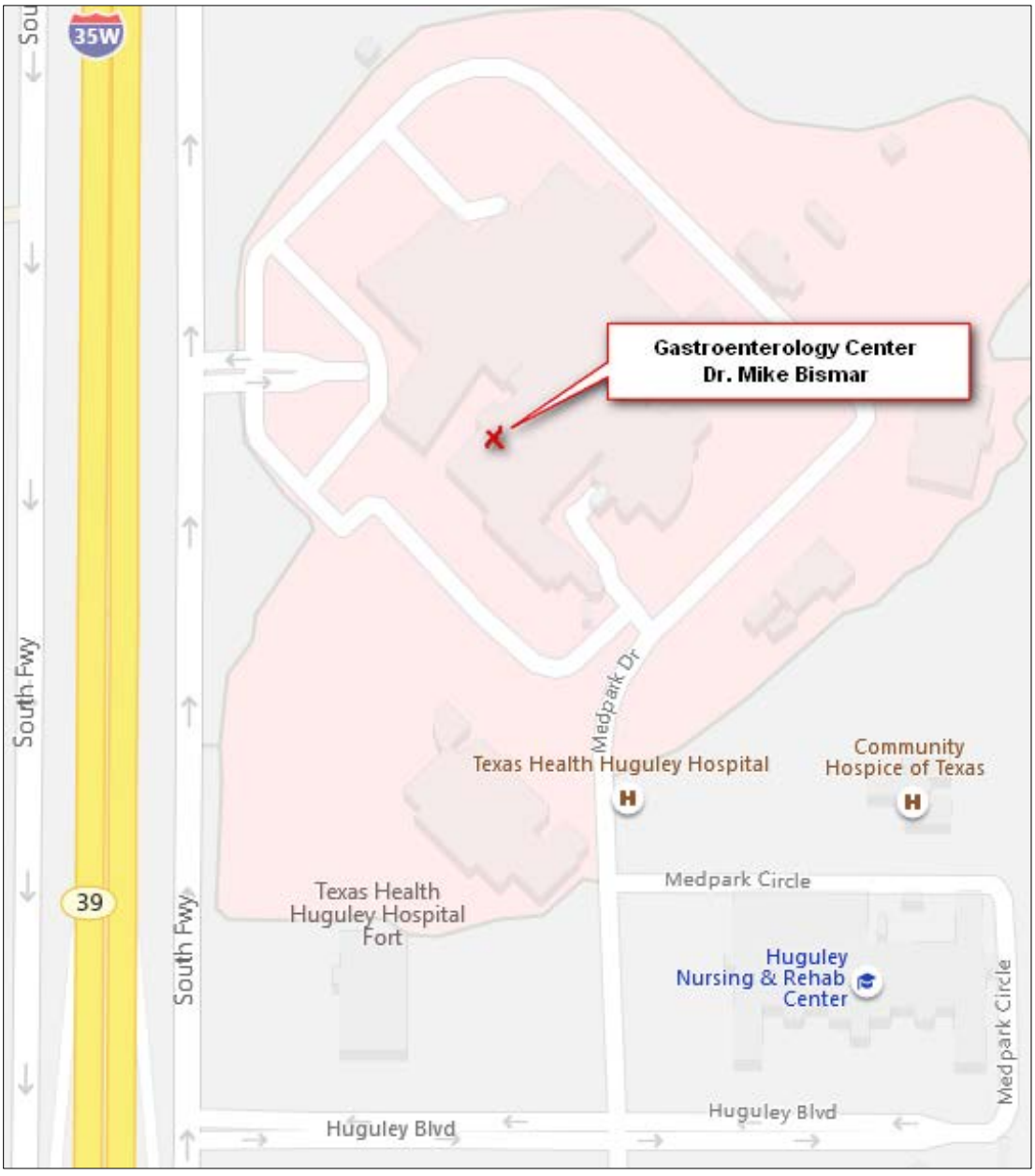
Gastroenterology Center: Medical Office Building 3
11797 South Fwy, Suite 136, Burleson, TX 76028

Directions: Our Office is located in **Huguley Hospital Main Building,** 1st floor, down the hallway that is next to **Starbucks Coffee** on the right.

From I-35 West (South Freeway), Take **1187 Rendon-Crowley Exit # 39**. The building is located on the frontage road on the east side of I-35.



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New Patient Registration

Male Female Single Married Divorced Separated Widowed

Last Name: _____ First: _____ MI: _____

Social Sec No: _____ _____ _____ DOB: _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ _____ Home: _____ _____

Email: _____ Employed By: _____

Emergency Contact (important in case of emergencies)**:**

Name: _____ Phone: _____ Relationship: _____

Preferred Pharmacy (for prescriptions and refills if applicable):

Name: _____ Phone: _____ Location: _____

Insurance Information:

1primary Insurance: _____ 2ndary Insurance: _____

1primary ID#: _____ 2ndary ID#: _____

1primary Group ID: _____ 2ndary Group ID: _____

1primary Phone: _____ 2ndary Phone: _____

Insured Name (Insurance Policy Holder): Relation to Patient: Self Spouse Parent Child Other_____

Last Name: _____ First: _____ DOB: _____

Social Sec No: _____ _____ _____ Phone: _____

_____ _____ _____

Patient or Legal Representative Name **Signature** **Date**

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List doctors you have seen in the past so we may contact them to obtain your medical records:

	Primary Care Physician	Referring Physician	Gastroenterologist (previously seen)
Full Name			
Address			
Phone #			

Please initial the following and sign below acknowledging that you have read and understood them:

- The above information is true to the best of my knowledge …… **Initials:** _____

- I acknowledge receipt of Gastroenterology Center PA, Notice of Patient Information Privacy Practices …….. **Initials:** _____

- I authorize my medical insurance benefits and/or government benefits be paid directly to the physician/Gastroenterology Center PA ..... **Initials:** _____

- I understand that I am financially responsible for any charges not covered by my insurance company …… **Initials:** _____

- There will be a charge of $25.00 for every returned check…… **Initials:** _____

- If I fail to meet my financial obligations, Gastroenterology Center PA, reserves the right to add a monthly interest of 3% to any outstanding balance after 30 days. After 45 days this account will be forwarded to a collection agency. I agree to pay all collection costs involved including reasonable attorney fees and court costs. Furthermore, the collection agency will report the patient's name and any unpaid balances to national credit bureaus ……..... **Initials:** _____

- I authorize the Gastroenterology Center PA and my insurance company to release any information required to process my claims …… **Initials:** _____

- I authorize the Gastroenterology Center PA to release my health records/health information to any physician or facility involved in the treatment of my conditions in either verbal or written format, unless otherwise revoked in writing …….. **Initials:** _____

Patient or Legal Representative Name _____ **Signature** _____ **Date** _____

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Gastroenterology Center PA Policies:

Professional Fees: Gastroenterology Center PA, will bill your primary, secondary and tertiary insurance companies for services provided. Payment of all co-payments, co-insurances, deductibles and charges for non-covered related services are due at the time services are rendered. Surgical co-payments and deductible amounts for the **physician part** only are collected at the time of your pre-op visit. Please keep in mind that the amount given for the physician's fee for the procedure is only an **estimate**. A quote of insurance benefits is not a guarantee of payment. Approval of payment is made upon receipt of the claim. It is the **patient's responsibility** to contact the hospital/medical facility where the procedure will take place to obtain amounts that you owed or may owe for that facility, anesthesia, pathology, imaging and any other service related to the surgical procedures, these amounts are independent and separate from our physician's fee …….. **Initials:** _____

Medical Records: Copies of your medical records will be furnished to another physician at no charge upon receipt of a properly executed medical records release form. Copies of your medical records for legal or insurance use are furnished upon receipt of a signed medical release and a prepayment of $25. Requested records may be retained until payment is received. Please allow 14 business days for your request to be processed ……. **Initials:** _____

Emergency Call: If you have an emergency outside business hours, please call 911 …. I**nitials:** _____

Non-Emergency Calls: If you have non-emergency call for refill, labs, radiology or pathology results, please call our office. Our Medical Assistant will return your call on the next business day ……..... **Initials:** _____

Prescription Refills: Our office requires 2 business days' notice for prescription refills. Please call your pharmacy if you need a refill and they will contact our office for approval. Refill requests are processed during business hours.
Please call ahead of time for refill before you run out of your medication(s)…… **Initials:** _____

No-Show: If you do not cancel or reschedule your appointment with at least 24-hour notice, we may assess a $100 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it. After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you …….. **Initials:** _____

I have read the office policies of Gastroenterology Center PA; I understand and agree to the above policies.

_____	_____	_____
Patient or Legal Representative Name	**Signature**	**Date**

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Release of Patient Health Information and Confidential Communication Request

This form indicates the means and communications that I prefer to remind me of my appointments, procedures, test results, inquiries and follow-up visits.

I consent to the release of any medical information or test results to the following persons:

My Spouse: _____
name

My Child/Children: _____
name(s)

My Parents: _____
name(s)

Other: _____
name(s)

I wish to be contacted in the following manner (circle all that apply):

Home Phone:_____

□ I give permission to leave a message with detailed information.

□ Only Leave name / doctor with call back number.

Cell Phone:_____

□ I give permission to leave a message with detailed information.

□ Only Leave name / doctor with call back number.

Patient Portal, Email: _____

When unable to contact me by phone, a written communication may be sent to:

Home Address (on file):

_____

_____

Alternate Address:

_____

_____

Patient or Legal Representative Name **Signature** **Date**

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Credit Card Authorization Form

In order to benefit both patient and provider, the Gastroenterology Center PA requests a signed credit card authorization form on file for each patient. This information will be held securely and used to pay balances on your account not to exceed $100. We will contact you prior to your credit card transaction if the amount will exceed $100. You may also authorize us by phone to charge the card for payment of services or treatment cycles.

Completion of this form helps us protect you from credit card fraud. Gastroenterology Center PA will keep all your information entered on this form strictly confidential, and this authorization will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment. All applicable copays, coinsurance and deductibles will still apply and be due at the time of service.

Patient Name _____
please print

Cardholder Name _____
as it appears on the card

Type of card (circle) Visa Mastercard Discover AmEx

Card Number _____

Expiration Date _____ 3-digit Code _____
mm/yyyy (located on the back)

Card Billing Address _____ Billing Zip code _____

I, _____ hereby authorize the Gastroenterology Center PA to charge my credit card account in an amount not to exceed $100 for services rendered, unless I have been contacted in advance for approval of charges that will exceed $100.

Cardholder Signature _____ Date _____

Gastroenterology Center's Witness _____ Date _____

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NEW PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____ AGE: _____

CURRENT PROBLEM/CONCERN: _____

IN THE PAST, HAVE YOU HAD ANY COMPLICATIONS WITH ANESTHESIA OR CONSCIOUS SEDATION (CIRCLE ONE)?

No Yes If yes, explain: _____

ACCURATE PROCEDURES HISTORY (VERY IMPORTANT SO WE CAN REQUEST YOUR MEDICAL RECORDS AND PREVIOUS PROCEDURES FINDINGS)

TEST	DATE	REASON	FINDINGS	DOCTOR	LOCATION
EGD					
Colonoscopy					
Flexible Sig					

HAVE YOU HAD ANY OF THE FOLLOWING SURGERIES (CIRCLE ALL THAT APPLIES)?

SURGERY	MONTH/ YEAR	SURGERY	MONTH/ YEAR	SURGERY	MONTH/ YEAR
Angioplasty/ Heart Stent		Appendectomy		Hernia Repair Type:	
Heart Bypass / CABG		Bowel Obstruction		Breast	
Heart Valve Replacement		Gallbladder Removal		Hysterectomy	
Other:					

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING (CIRCLE ALL THAT APPLIES)?

Colon Polyps	Liver Disease	Heart Disease	Arthritis	Anemia
Colon Cancer	Pancreatitis	Arrhythmia / Afib	Asthma / COPD	Anxiety
Ulcers, where:	Diabetes	Palpations	Pneumonia	Hypertension
Esophageal Disease	Thyroid Disease	Heart Failure	Obstructive Sleep Apnea	Depression
Hepatitis: A B C D	High Cholesterol	Heart Attack / MI	Using CPAP Machine	Other:

FAMILY MEDICAL HISTORY	RELATIONSHIP	DETAILS / COMPLICATIONS
GI or Liver Disease		
Cancer		Type:
Other:		

SOCIAL BEHAVIORS, ARE YOU CURRENTLY OR HAVE YOU EVER USED ANY OF THE FOLLOWING:

Tobacco	Packs Per Day?	Number of Years?	Date Stopped:
Alcohol	How Many Drinks?	Day Week Month (circle one)	Date Stopped:
Recreational Drugs	If Yes, What Kind?		Date Stopped:

OCCUPATION:	

DRUG ALLERGIES:	NONE YES, LIST ALL: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION NAME	DOSAGE	FREQUENCY	MEDICATION NAME	DOSAGE	FREQUENCY
1)			4)		
2)			5)		
3)			6)		

PATIENT NAME: _____

REVIEW OF SYSTEMS: IN THE PAST MONTHS, HAVE YOU HAD PROBLEMS WITH THE FOLLOWING (CIRCLE ALL THAT APPLIES OR *NO COMPLAINTS*)?

GASTROINTESTINAL	HOW LONG	GASTROINTESTINAL	HOW LONG
Difficulty /Pain with Swallowing: Liquids / Solids		Diarrhea: Loose /Watery with Blood /without Blood	
Nausea /Vomiting: Food Particles / Blood / Other		Constipation Thin Stool	
Indigestion		Blood in Stool	
Heartburn Food Regurgitation		Other:	
Abdominal Pain		Other:	

CONSTITUTIONAL	**NO COMPLAINTS**				
Loss of Appetite	Weight Loss: Lbs Over: Weeks / Months Intentional Unintentional				
Night Sweats	Fever	Chills	Fatigue	Other:	
EYES	**NO COMPLAINTS**	Double Vision	Blurred Vision	Pain	Other:
EARS / MOUTH / THROAT	**NO COMPLAINTS**	Sinus Pressure	Decrease in Hearing	Nose Bleed	Clearing Throat
	Ear Pain	Ulcers in Mouth	Sore Throat	Other:	
CARDIOVASCULAR	**NO COMPLAINTS**	Chest pain	Edema	Shortness of Breath on Exertion	
	Shortness of Breath While Lying Flat		Palpitation	Other:	
RESPIRATORY	**NO COMPLAINTS**	Cough	Wheezing	Shortness of Breath	Coughing Blood
GU / GYNECOLOGY	**NO COMPLAINTS**	Pain with urination	Urgency	Spotting / Bleeding	Discharge
	Cramps	Pregnant Weeks	Possible Pregnancy	Other:	
MUSCULOSKELETAL	**NO COMPLAINTS**	Joint Swelling	Stiffness	Painful joint (s) location:	
	Painful muscle:		Other:		
NEUROLOGICAL	**NO COMPLAINTS**	Headache	Seizures	Dizziness	Fainting Episodes
	Numbness, where:		Syncope	Other:	
ENDOCRINE	**NO COMPLAINTS**	Excessive Thirst	Temp Intolerance to Heat / Cold	Increase Frequency of Urination	Other:
SKIN	**NO COMPLAINTS**	Rash	Itching	Bruises	Hair Loss
HEM / LYMPHATIC	**NO COMPLAINTS**	Easy bruising	Bleeding	Blood Transfusions	Lymph Nodes
PSYCHIATRIC	**NO COMPLAINTS**	Depressed mood	Anxiety	Suicidal Attempts	Suicidal Thoughts, Past or Present
ALLERGY / IMMUNOLOGIC	**NO COMPLAINTS**	Allergy Symptoms/Reactions	Immune Problems	Other:	

_____ _____ _____

PATIENT OR LEGAL REPRESENTATIVE NAME SIGNATURE DATE

THE ABOVE REVIEW OF SYSTEMS DISCUSSED WITH PATIENT: _____

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Consent to Release of Health Care Information

General Release of Information
I acknowledge that I have received a copy of the Gastroenterology Center PA's (the "Gastroenterology Center") Notice of Patient Information Privacy Practices, which describes the permitted uses and disclosures of my health care information related to my care by the Gastroenterology Center, and payment of my charges for the services received at the Gastroenterology Center. I specifically authorize the uses and disclosures of my health care information described in the Gastroenterology Center's Notice of Patient Information Privacy Practices.

I consent to release of my health care information, including but not limited to medical, psychiatric, substance abuse or HIV information, for medical purposes and for payment purposes to third parties including but not limited to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of my charges for the services received at the Gastroenterology Center, EXCEPT:

☐ _____

_____ (Please specify)

☐ None _____ (Please initial)

Health Information Exchange
Health information exchange allows health care providers to share health care information about patients electronically for several purposes, such as treatment, quality assurance and state law reporting requirements. I understand that if I go to the Gastroenterology Center for treatment, the Physicians and/or their staff may get a copy of my health care information electronically through various health information exchange connections with other health care providers.

I understand I may request that my health care information not be shared through electronic health information exchange by following the directions in the Notice of Patient Information Privacy Practices.

Substance Abuse
I authorize the Gastroenterology Center to release all of my substance abuse health care information (which includes drug and alcohol abuse information) to the hospitals, physicians and care providers who are treating me for my treatment, payment of the health care services I receive and health care operations activities, like quality assurance and peer review.

I understand that this authorization for release of substance abuse health care information may be terminated at any time, unless the Gastroenterology Center have already acted in reliance on it. If not previously revoked, I understand that this authorization is effective until I die. I further understand that I may decline to sign this authorization today by checking the box below.

____ Decline

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THE UNDERSIGNED MAY RECEIVE A COPY OF THIS AGREEMENT UPON REQUEST, AND CERTIFIES THAT HE OR SHE HAS READ THIS RELEASE AND HAS BEEN ABLE TO ASK QUESTIONS.

_____ _____
Printed Name of Patient Printed Name of Witness

_____ _____
Patient's Signature & Date Witness' Signature & Date

_____ _____
Printed Name of Legal Representative Legal Representative Signature & Date

_____
Relationship to Patient (Self, Legal Representative, Principal Obligator, General Agent)

IF THE PATIENT, PRINCIPAL OBLIGOR, LEGAL REPRESENTATIVE, OR GENERAL AGENT IS ONLY ABLE TO GIVE VERBAL CONSENT, AS AN EMPLOYEE OF THE GASTROENTEROLOGY CENTER I HAVE SIGNED THIS FORM ON BEHALF OF THE PATIENT TO ACKNOWLEDGE THE VERBAL CONSENT BY THE PATIENT OR THE PATIENT'S PRINCIPAL OBLIGOR, LEGAL REPRESENTATIVE, OR GENERAL AGENT, TO THE PROVISION OF TREATMENT BY THE GASTROENTEROLOGY CENTER.

_____
Printed Name of Patient Reason Verbal Consent Obtained

_____ _____
Printed Name of Individual Providing Verbal Consent Relationship to Patient (Self, Principal Obligor, Legal Representative or General Agent)

_____
Gastroenterology Center Employee's Signature & Date

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NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, to be kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, "*Gastroenterology Center PA"* (The "GI Center") have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We jointly participate in this notification, and will share protected health information (PHI) with each other, as necessary, to carry out treatment, payment, or healthcare operations relating to the organized.

USES AND DISCLOSURES OF HEALTH INFORMATION
GI Center may use and disclose your protected health information for treatment, obtaining payment for treatment, and healthcare operations necessary to sustain our business. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

An example of this would be: A physical examination or assessment.

Payment means such activities as obtaining reimbursement for services, confirmation coverage, billing or collection activities and utilization review.

An example of this would be: We may provide information to your insurance company as needed to receive payment for services rendered to you. This may include, but is not limited to, diagnosis and treatment codes, treatment notes, and copies of documentation relevant to obtaining payment. Your insurance company, health plan, health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.

Healthcare Operations includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

An example of this would be: We may use your personal information to contact you to remind you of an upcoming appointment, either by phone or by mail.

GI Center may also use or disclose your protected health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

In any other situation, GI Center policy is to obtain your written authorization before disclosing your protected health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

GI Center may change its policy at any time. This amendment will affect all protected health information maintained by the GI Center. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting room areas that will display the Effective Dates and any Revision Dates. You may also request an updated copy of our current Notice of Patient Information Practices at any time.

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PATIENT'S INDIVIDUAL RIGHTS
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- You have the right to review or obtain a copy of your protected health information at any time.
- You have the right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure of family member, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. You may also request in writing that we not use or disclose your protected health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. GI Center will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.
- You have the right to request that we amend your protected health information.
- You also have the right to request a list of instances where we have disclosed your protected health information for reasons other than treatment, payment or other related administrative purposes.
- You have the right to obtain a paper copy of this notice from us upon request.

CONCERNS AND COMPLAINTS
If you are concerned that the GI Center may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your protected health information, please contact our Privacy Officer or Quality Assurance Department at the address listed below. It is our intent to protect and keep your protected health information confidential. Your alerting us of any concerns you may have is a necessary part of a continuous quality process we employ. You will, in no way, be retaliated against for filing a complaint. You may also send a written complaint to the US Department of Health and Human Services. For further information on the GI Center's health information practices or if you have a complaint, please contact the following person:

Gastroenterology Center PA
Attention Privacy Officer
PO Box 16657
Fort Worth, TX 76162

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Medical Records Request

Name of Physician or Medical Facility from which records are being requested:

1. _____
   Name Telephone Address

2. _____
   Name Telephone Address

3. _____
   Name Telephone Address

I, _____, hereby request my medical records and my
printed patient name
Protected Health Information to be released to:

Gastroenterology Center PA
Mike Bismar, MD
11797 South Fwy, Suite 136
Burleson, Texas 76028
Tel: 817-551-6161 Fax: 817-551-6177

Please include the following:

___History and Physical

___Progress Notes and Office Visits

___Labs / Pathology Results / CT Scans

___EGD / Colonoscopy Reports

___Hepatitis Results

___AIDS/HIV Results. I consent to the release of AIDS/HIV status with my records, initials ____

Other Records: _____, initials____

_____ _____
Patient Social Security No Patient Date of Birth

_____ _____ _____
Patient or Legal Representative Name Signature Date

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Patient Notice for Tests, Labs, Imaging and Referrals

The Gastroenterology Center PA may order tests, including Lab (blood) works, X-Rays, CT-Scans, other imaging or endoscopy procedures, a follow up appointment will be scheduled to discuss the results with the patient.

Our office will NOT contact the patient with the results. The results also will not be discussed at the time of the endoscopy procedure. However, typically 7 business days after the testing has been completed, the patient may access the **"Patient Portal"** to check on the results. Some results may take longer.

If it is not possible to access the results within 14 business days, the patient must contact our office to discuss the reason. **It is the responsibility of the patient to contact our office to discuss the results over the phone if it is not possible to attend the follow up appointment.**

If the patient has testing performed at a location or facility other than Huguley Hospital Lab, it is the **patient responsibility** to have the results sent to our office before the follow up visit.

If we refer the patient to another facility or doctor, it is the patient responsibility to contact the facility or the doctor to obtain appointment.

It is imperative that the patient follows the treatment plan, takes the prescribed medications, completes all ordered tests, procedures and referrals, and timely follow up on results.

Patient or Legal Representative Name	Signature	Date

copy to the patient
scan copy into patient chart

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Understanding Your Medical Bills

If you are scheduled for a procedure, the procedure you will have will be performed by a (1) physician of the Gastroenterology Center PA (2) At a separate medical facility. (3) Anesthesia will be administered by an anesthesiologist. (4) Pathology slides will be read by a pathologist.

You can expect to receive separate bills from each of the following:

1. Physician: Gastroenterology Center, (Mike Bismar, MD)
2. Medical facility (hospital or outpatient surgery center)
3. Anesthesiologist (if used)
4. Pathologist (if specimens taken)

1. Bill from the Physician (Gastroenterology Center PA): When you have a procedure, the physician bills for the professional fee. The physician bill will include the basic procedure and any additional procedures which may be required such as: dilation, polypectomy or biopsy. Due to many variables during the procedure, a **definite cost cannot be predetermined until the physician has completed the procedure.** The total cost incurred may be obtained from the physician's office ***after*** the procedure is completed. Copays, coinsurances and deductibles are to be paid prior to the procedure being scheduled. Please note that if you have been scheduled for screening colonoscopy and the physician **finds** a polyp or tissue that has to be removed during the procedure, this colonoscopy is NO longer considered as screening procedure, it is considered a surgical (diagnostic) procedure and will be coded and billed to your insurance company as such. If so, more likely your insurance benefits **will change** accordingly. Please check with your insurance company prior to starting your procedure preparation. In performing procedures, our physician is practicing the standard of care which we believe best serves your needs. Medicare and/or your insurance company may not accept the same standards and indications for a certain procedure and therefore may deny payment for your procedure.

2. Bill from the Medical Facility: You are scheduled to have your procedure performed in a medical facility (hospital or outpatient surgery center, …). You will have a charge from this facility. This is a separate bill from the physician's charges. Please check with the assigned medical facility in advance for more information and to learn about their policy. We do not have control or access to the facility billing info.

3. Bill for the Anesthesia (if used): An anesthesiologist that has been chosen by the medical facility will administer the anesthesia. You will receive a separate bill from the anesthesiologist. Please check with the medical facility for more information about the anesthesia. We do not have control or access to the anesthesiology billing info.

4. Bill for the Pathology (if specimens taken): A pathologist that has been chosen by the medical facility will read the specimen slides. You will receive a separate bill from the pathologist. Please check with the medical facility for more information. We do not have control or access to the pathology billing info.

If you have any question, please discuss them with our billing department prior to services being rendered.

I have read the above statements and understand that the Gastroenterology Center PA will bill me separately for any outstanding balance resulting from the services rendered by the physician. I also understand that I am responsible for any balance after my insurance company has paid.

Patient or Legal Representative Name	Signature	Date