ADVANCED GI Inc
555 Marin Street, Suite 270, Thousand Oaks, CA 91360
Tel: 805-719-0244 Fax: 805-777-1730
WWW.AGIMEDICAL.COM

Patient Registration

❑ New patient registration ❑ Updated patient registration Sex: ❑ Male ❑ Female
Name (First, MI, Last): _____ **Date of Birth**: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary phone: _____ Cell phone: _____ Other: _____
Email address: _____ Driver's license number: _____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partner ❑ Separated
Race: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian/Alaska Native
❑ Native Hawaiian/Pacific Islander ❑ Decline to specify
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline to specify ❑ Other: _____

Referring physician: _____ Phone number: _____
Primary care physician: _____ Phone number: _____
***To establish care with Advanced Gastroenterology Inc., you must have a primary care doctor**
How did you hear about us? ❑ Physician: _____ ❑ Friend ❑ Family ❑ Los Robles Hospital
❑ Newspaper: _____ ❑ Online: _____ ❑ Other: _____

Pharmacy:
Our office can send prescriptions electronically to your preferred pharmacy. Do you consent our staff to obtain your current pharmacy records and/or electronic prescriptions? ❑ Yes ❑ No
Pharmacy: _____ Phone number: _____
Address: _____ City: _____ State: _____ Zip: _____

Emergency contact:
Name: _____ Relationship: _____ Phone: _____

Patient employment information:
Employment status: ❑ Full-time ❑ Part-time ❑ Unemployed ❑ Self-employed ❑ Retired
Employer name: _____ Phone number: _____
Address: _____ City: _____ State: _____ Zip: _____
Student status: ❑ Full-time student ❑ Part-time student ❑ Not a student

Insurance information:
If you are insured through someone else, please list that person's information below.
PRIMARY INSURANCE INFORMATION
Insurance company: _____ Member ID: _____
Group/Policy number: _____ Subscriber's name: _____
Subscriber's date of birth: _____ Relationship to patient: _____
Subscriber's employer: _____ Subscriber's SSN: _____
Subscriber's employer address: _____
Subscriber's employer phone: _____

SECONDARY INSURANCE INFORMATION
Insurance company: _____ Member ID: _____
Group/Policy number: _____ Subscriber's name: _____
Subscriber's date of birth: _____ Relationship to patient: _____
Subscriber's employer: _____ Subscriber's SSN: _____
Subscriber's employer address: _____
Subscriber's employer phone: _____

Advance Directive:
Please check one of the following boxes: ❑ Do not intubate ❑ Do not resuscitate ❑ Not interested to Answer

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Insured Patient Payment Policy

Patient Responsibility: You are responsible for all charges resulting from treatment provided by Advanced Gastroenterology Inc (AGI). We will bill most insurance carriers, however you are primary responsible for any charges to your account. Your copayment is due at the time of service and any remaining balance owed on your account is due when you receive a statement unless other financial arrangements are made. If you have a delinquent balance, you will be expected to make a payment at your next visit.
Minors: Advanced Gastroenterology Inc does not provide any pediatric gastroenterology care.
Insurance Billing: It is the patient's or the financially responsible party's responsibility to provide current and accurate insurance billing information. If your insurance information changes, you MUST provide the new insurance information to AGI prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover services that you receive, you will be responsible for any charges applied to your account at that time. As a courtesy, our staff will verify your insurance benefits, however, it is the patient's responsibility to ensure that your policy is in fact IN-NETWORK with AGI at the time the medical services are rendered. Please see the AGI disclaimer regarding insurance carrier(s) and benefits.
Statements: Payment is due upon receipt. AGI reserves the right to charge a $45.00 late fee for all past due balances after 30 days of the receipt of your statement. All patients are financially responsible for the full amount on all services not covered by your insurance carrier. We will bill your secondary insurance carrier as a courtesy. If your secondary insurance carrier does not pay for any reason the patient is financially responsible for the full amount of unpaid services. For billing questions or to make a payment, please contact our billing department at 805-210-5491.
Medicare: We are in-network with Medicare and will bill Medicare as your primary insurance carrier and bill your supplemental insurance carrier.
Medical: We are NOT contracted with Medical. You will be fully responsible for services provided to you.
Returned checks: It is our office policy to charge a $100 fee for checks that are returned due to insufficient funds.
Authorization to release information: In obtaining payment for services, I authorize my healthcare provider, Advanced Gastroenterology Inc, to provide information from my medical record to any company that may be responsible for payment for all or part of provider charges, including but not limited to my insurance companies and their representatives and/or my employer or union if they are involved in processing the claim. I have been provided with a copy of the Notice of Privacy Information Practices. For further information regarding disclosure of health information. Please refer to the Notice of Privacy Information Practices which has been provided to you and is available in our office or on our website: www.agimedical.com

If I have been referred by or am being referred to another healthcare provider, I authorize Advanced Gastroenterology Inc to release my medical information to this provider for continuity of care. I also assign Advanced Gastroenterology Inc all payments to which I am entitled for medical expenses related to the services reported herewith. I understand that I am financially responsible for all charges whether covered by my insurance provider or not. I also understand that balances outstanding for more than 90 days may be subject to a processing and/or collection fee.

Please answer the following questions:

Did you sustain an injury at work? ❑ Yes ❑ No
Are your injuries work related? ❑ Yes ❑ No
Are you currently employed? ❑ Yes ❑ No
Have you ever served in the military? ❑ Yes ❑ No
Are you a new patient to this practice? ❑ Yes ❑ No
Do you have a secondary insurance policy? ❑ Yes ❑ No
Is your spouse or another family member employed? ❑ Yes ❑ No
Are you covered under any other health care plan? ❑ Yes ❑ No
Are you covered under an employer/union policy? ❑ Yes ❑ No
Have you made any changes to your choice of Medicare options in the last enrollment period? ❑ Yes ❑ No

(initials) _____ I have received Office Anesthesia Notice
(initials) _____ I have received Office Prior Authorization Policy
(initials) _____ I have received The Open Payments database info.
(initials) _____ I have received Office Insurance Disclaimer Notice
(initials) _____ I have received Office IN-NETWORK Plans notice

Who is responsible for billing for services rendered? Name: _____ Relationship: _____
I, or my appointed agent, have read, fully understand, and agree to the above statements. I can request a copy of this policy at any time. I attest that the information I have given here is correct and true to the best of my knowledge. I understand that I am responsible for keeping the doctor updated with the current information regarding my account.

_____ _____ _____
PATIENT NAME PATIENT SIGNATURE DATE

If the patient is under the age of 18, or is otherwise unable to sign, complete the following:
Patient is ___ years of age or is unable to sign because of _____

_____ _____ _____
PATIENT NAME PATIENT SIGNATURE DATE

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Health Insurance Portability and Accountability Act (HIPAA) Practices

The HIPAA privacy law gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided with the right to request confidential communications or that a communication of protected health information is made by alternative means, such as sending correspondence to the individuals office instead of the individuals' home.

Your medical records and health information are confidential and protected under HIPAA. We take the responsibility to secure your medical information seriously. Please advise us with whom we may share your information directly with. No information will be given to any person unless they have your expressed authorization below.

Please check one of the boxes below and indicate name(s):

❑ Spouse Name: _____ Phone number: _____

❑ Parent Name: _____ Phone number: _____

❑ Guardian Name: _____ Phone number: _____

❑ Child Name: _____ Phone number: _____

❑ Partner Name: _____ Phone number: _____

❑ Other Name: _____ Phone number: _____

I wish to be contacted in the following manner, please check all that apply:

❑ Home phone Phone number: _____

❑ Work phone Phone number: _____

❑ Cell phone Phone number: _____

❑ Fax Fax number: _____

❑ Email Email address: _____

❑ Other _____

I wish to receive my account statements and appointment reminders via email and/or patient portal:

❑ Yes

❑ No

My signature below constitutes my acknowledgement that I have been advised of the HIPAA privacy rule.

_____ _____ _____

PATIENT NAME PATIENT SIGNATURE DATE

If not signed by patient, please indicate relationship: _____

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Notice

"For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. https://openpaymentsdata.cms.gov

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public."

Patient Name (Please Print)	Signature of Patient or Representative	Date

ADVANCED GI

Patient Health History

Name (First, Last): _____ Date: _____

Chief complaint: _____ Height: ___'___" Sex: ❑ Male ❑ Female

Current medications: ❑ None Please Include any vitamins or supplements

Name of medication	Dosage/Strength (i.e., mg, units)	Frequency (i.e. once a day, As needed, every night)

Past or present medical conditions: ❑ None

Gastrointestinal:
- ❑ Hepatitis
- ❑ Jaundice
- ❑ Cirrhosis
- ❑ Liver disease
- ❑ Peptic ulcer disease
- ❑ Lactose intolerance
- ❑ GERD/heartburn
- ❑ Pancreatitis
- ❑ Gallstones
- ❑ Diverticulitis

Cardiovascular:
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ High triglycerides
- ❑ History of heart attack

Respiratory:
- ❑ Chronic bronchitis
- ❑ Asthma
- ❑ Sleep apnea

Neurology:
- ❑ Migraine headaches
- ❑ Stroke
- ❑ T.I.A.
- ❑ Seizure

Endocrine:
- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Diabetes
- ❑ Hypothyroid
- ❑ Hyperthyroidism

Genitourinary:
- ❑ Kidney stone
- ❑ Kidney failure
- ❑ Prostate enlargement

Eye:
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Conjunctivitis

Rheumatology:
- ❑ Arthritis
- ❑ Lupus
- ❑ Rheumatoid arthritis
- ❑ Sjogren's
- ❑ Scleroderma

Psychology:
- ❑ Anxiety
- ❑ Depression
- ❑ Panic attacks

Hematology:
- ❑ Anemia
- ❑ Blood disorder
- ❑ History of leg clots (DVT)

Oncology:
- ❑ Breast cancer
- ❑ Colon cancer
- ❑ Prostate cancer
- ❑ Pancreatic cancer

Other medical condition(s) not listed above: _____

Allergies: ❑ None
- ❑ Iodine
- ❑ Dye
- ❑ Tape
- ❑ Erythromycin
- ❑ Keflex
- ❑ Latex
- ❑ Penicillin
- ❑ Codeine
- ❑ Sulfa
- ❑ Other: _____

Please note your reaction to each allergy: _____

Surgical History: ❑ None
- ❑ Appendectomy
- ❑ Hysterectomy
- ❑ C-section
- ❑ Gallbladder removal
- ❑ Hernia repair
- ❑Laparoscopy
- ❑ Gastric bypass
- ❑ Gastric banding
- ❑ TIF
- ❑ Nissen fundoplication
- ❑ Coronary artery bypass
- ❑ Heart valve replacement
- ❑ Pacemaker
- ❑ Defibrillator

❑ Colonoscopy Date: _____ Findings: _____ Physician: _____

❑ Endoscopy (EGD) Date: _____ Findings: _____ Physician: _____

❑ Other abdominal surgery: _____

❑ Other surgery not listed: _____

Hospitalizations: ❑ None
Past hospitalization – Date: _____ Reason: _____
Past hospitalization – Date: _____ Reason: _____

Family History: ❑ None ❑ Adopted/Unknown ❑ No family history of colon cancer ❑ No family history of autoimmune disease
❑ No family history of inflammatory bowel disease (IBD) – Crohn's Disease or Ulcerative Colitis
F – Father M – Mother B – Brother S – Sister GF – Grandfather GM – Grandmother Please indicate: P – Paternal M – Maternal

❑ Colon cancer – Relation: _____ Age: ____
❑ Esophageal cancer – Relation: _____ Age: ____
❑ Stomach cancer – Relation: _____ Age: ____
❑ Ovarian cancer – Relation: _____ Age: ____
❑ Prostate cancer – Relation: _____ Age: ____
❑ Uterine cancer – Relation: _____ Age: ____
❑ Bladder cancer – Relation: _____ Age: ____
❑ Pancreatic cancer – Relation: _____ Age: ____
❑ Pancreatitis – Relation: _____ Age: ____
❑ Ulcerative colitis – Relation: _____ Age: ____
❑ Crohn's disease – Relation: _____ Age: ____
❑ Celiac disease – Relation: _____ Age: ____

❑ Peptic ulcer disease – Relation: _____ Age: ____
❑ Liver disease – Relation: _____ Age: ____
❑ Cirrhosis – Relation: _____ Age: ____
❑ Gallbladder disease – Relation: _____ Age: ____
❑ Gallstones – Relation: _____ Age: ____
❑ Barrett's esophagus – Relation: _____ Age: ____
❑ Colon polyp – Relation: _____ Age: ____
❑ Hemochromatosis – Relation: _____ Age: ____
❑ Rheumatoid arthritis – Relation: _____ Age: ____
❑ Lupus – Relation: _____ Age: ____
❑ Sjogren's syndrome – Relation: _____ Age: ____

❑ Other: _____ – Relation: _____ Age: ____
❑ Other: _____ – Relation: _____ Age: ____

Immunizations: ❑ None
❑ **Flu/Influenza** Date: _____
❑ **COVID-19** Date(s): _____
❑ **Tetanus** Date: _____
❑ **Hepatitis A** Date: _____
❑ **Hepatitis B** Date: _____
❑ **Shingles** Date: _____
❑ **Pneumonia** Date: _____

Social History:
Tobacco use: ❑ Current smoker ❑ Nonsmoker ❑ Unknown if ever smoked ❑ Former smoker – stopped smoking: _____
Drug use: ❑ No ❑ Yes – please list the type, quantity, and how often you use them: _____
Marijuana: ❑ Yes ❑ No Frequency of marijuana use: _____
Alcohol: ❑ Yes ❑ No ❑ Socially ❑ Daily Frequency of alcohol consumption: _____
Caffeine: ❑ No ❑ 1-2 cups per day ❑ 2-3 cups per day ❑ 3-4 cups per day ❑ 4 or more cups per day
Exercise: ❑ None ❑ Daily ❑ Once a week ❑ Twice a week ❑ Three times a week ❑ Occasionally
Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Living with significant other
Employment status: ❑ Unemployed ❑ Self-employed ❑ Full-time ❑ Part-time ❑ Retired ❑ Occupation: _____

Review of symptoms: ❑ None
General/Constitutional: ❑ Chills ❑ Fatigue ❑ Fever ❑ Weight loss
ENT: ❑ Hoarseness ❑ Oral ulcers ❑ Eye redness ❑ Sinusitis ❑ Post-nasal drip ❑ Throat clearing ❑ Sore throat
Endocrine: ❑ Excessive thirst ❑ Heat intolerance ❑ Thyroid problems
Respiratory: ❑ Breathing problems ❑ Cough ❑ Hemoptysis (coughing blood) ❑ Wheezing
Cardiovascular: ❑ Chest pain ❑ Claudication (leg cramps with exercise) ❑ Palpitations ❑ Swelling in hands/feet
Gastrointestinal: ❑ Gas ❑ Bloating ❑ Black stool ❑ Painful swallowing (odynophagia) ❑ Fill up quickly at meals (early satiety)
❑ Loss of control of bowel movements (incontinence) ❑ Abdominal pain ❑ Blood in stool ❑ Constipation ❑ Diarrhea
❑ Difficulty swallowing ❑ Heartburn ❑ Hematemesis (vomiting blood) ❑ Nausea ❑ Rectal bleeding ❑ Vomiting
Hematology: ❑ Anemia ❑ Easy bruising ❑ Swollen glands (enlarged lymph nodes)
Genitourinary: ❑ Blood in urine ❑ Frequent urination ❑ Urinary incontinence ❑ Painful urination ❑ Excessive urination at night
Musculoskeletal: ❑ Back pain ❑ Joint stiffness ❑ Muscle cramps ❑ Painful joints
Skin: ❑ Bruising ❑ Itching ❑ Rash
Neurologic: ❑ Numbness ❑ Trouble walking ❑ Weakness in extremities
Psychiatric: ❑ Depression ❑ Difficulty sleeping (insomnia) ❑ Nervousness ❑ Suicidal thoughts

ADVANCED GI Inc

Financial Responsibility for Services From Out of Network Provider

I understand that Advanced Gastroenterology Inc and Dr. Gilbert Simoni are not providers for the health insurance plans listed below. I have voluntarily elected to seek treatment from an out of network provider for that plan. Should my health insurance plan change at any point while under the care of Dr. Simoni at Advanced Gastroenterology Inc, I am aware that he is not in network with the health insurance plans listed below. I accept full responsibility for charges incurred and will comply with demands for payment for services that otherwise may have been considered for payment by the plan listed below.

Out of network plans:

❑ Gold Coast

❑ Medical

❑ Medicaid

❑ Oscar

❑ Tricare

❑ Veteran's Association (VA)

❑ Blue Shield

❑ UnitedHealthcare

❑ HMO/IPA Name: _____

❑ Covered California Care – Advanced Gastroenterology Inc and Dr. Gilbert Simoni are ONLY contracted with Anthem Blue Cross under these plans

❑ Anthem Blue Cross – Federal Plans (federal plans typically have subscriber numbers that begin with an R)

❑ International insurance plans

In network plans:

❑ Anthem Blue Cross

❑ Anthem Blue Cross – Covered California Plan

❑ Aetna PPO (APCN and APCN Plus)

❑ Cigna PPO

❑ HealthNet PPO

❑ First Health PPO

❑ Medicare

If you have any questions or concerns regarding your specific health insurance plan, please contact your insurance company to determine if Dr. Simoni and Advanced Gastroenterology Inc are in network with your insurance. For your convenience, you may provide the representative you speak to with the NPI number and/or Tax ID number below.

Advanced Gastroenterology Inc (AGI)/Dr. Gilbert Simoni NPI: 149-797-0875 Tax ID: 92-0201403

Office Anesthesia Notice

This notice is for all patients who elect to have any outpatient procedure with Dr. Simoni. Patients who choose to have any outpatient procedures with Dr. Simoni need to be aware that their health insurance plan may not cover propofol (diprivan) anesthesia provided by an anesthesiologist for routine endoscopic examinations. Such plans will only provide coverage for local sedation, which is the use of intravenous sedatives and opiates administered by the gastroenterologist, without the presence of an anesthesiologist.

Dr. Simoni's office will not initiate or handle any part of the anesthesia prior authorization for this service. To determine how this service will be handled by your health insurance company, you need to contact your insurance company.

The anesthesiologists, for their portion of the procedure, have offered their services for the administration of propofol (diprivan) to our patients for the prices listed below. We recommend that you contact your insurance company ahead of time to discuss your responsibility regarding this service.

For patients scheduled at **Los Robles Medical Center (LRMC)**, the anesthesia group and their cash prices are listed below:

Conejo Los Robles Anesthesiology Medical Group Inc (CLRAMG) NPI: 182-117-1729 Phone: 805-578-3904

- Single procedure $350.00
- Double procedure $500.00
- ERCP $550.00

For patients scheduled at **Advanced Digestive Center of Southern California (ADCSC)**, the anesthesia group and their cash prices are listed below:

Tip Top Anesthesia NPI: 150-828-3698 Phone: 310-779-3025

- Single procedure $300
- Double procedure $450

We recommend that our patients avoid the potential discomfort or pain and numerous other problems associated with local sedation by opting for propofol (diprivan) instead.

This cash discount is only applicable for the day of your procedure, you will be expected to pay for your anesthesia on the day of service. For all questions regarding the anesthesia fee, please contact the anesthesia group that will be providing anesthesia for your procedure prior to your date of service.

I have read and understand that this does not make Advanced Gastroenterology Inc responsible for the billing processed by the anesthesia provider. I understand that this notice is making me aware of the decision I will have to make regarding anesthesia payment for any procedures I have done with Dr. Simoni. I understand that any billing questions regarding anesthesia must be directed to the anesthesiologist who will provide the service(s).

ADVANCED GI

Office Cancellation Policy

We understand that situations arise in which you must cancel your appointment. If you must cancel your appointment, we ask that you make sure to give Advanced Gastroenterology, Inc. at least 24-hour notice prior to your appointment time. This will allow us to offer the time to other patients who are waiting to be scheduled. If cancellations are made with less than 24-hour notice, we are unable to offer that appointment to other patients.

If you must cancel or reschedule your procedure, we ask that patients make sure to give us notice of cancellation no less than 5 business days from procedure date.

- Office appointments that are cancelled with less than 24-hour notice are subject to $75 cancellation fee.
- Ultrasound appointments cancelled with less than 24-hour notice are subject to $75 cancellation/No Show fee.
- Procedure(s) cancelled with less than 5 business day notice are subject to $250 cancellation fee.
- Procedure(s) that are rescheduled with less than 5 business day notice are subject to $75 rescheduling fee.

Patients who NO SHOW for Two or more appointments within a 12-month period may be subject to discharge from the practice and thus denied any future appointments.

The cancellation, rescheduling, and No-Show fees are the sole responsibility of the patient and must be paid in full prior to the patients next appointment. We understand that certain unavoidable circumstances may cause you to cancel within 24 hours of your appointment. In this instance, these fees may be waived, but only with Management approval. Advanced Gastroenterology, Inc. firmly believes that a good physician-patient relationship is based upon understanding and communication. For any questions regarding cancellation, rescheduling, and No-Show fees, please contact our billing department at 805-210-5491.

Office Financial Policy

A current insurance card must be presented at the time of your office visit. If Advanced Gastroenterology, Inc. and/or its providers are out of Network with your insurance carrier, the billing department will submit an Out of Network Insurance claim with your Insurance carrier as a courtesy. For any Out of Network Patients, a payment in full is due at the time of service.

Any payment for copays, deductibles, non-Covered services and patient balances are expected at the time of service. Please inform us if you need to make any payment plan arrangements.

We Charge a fee for the following services and items:

Copy of medical or billing records	$35 up to 25 pages, all additional pages are $0.25/page
Completing Work Disability forms, FMLA, etc.,	$45 (TIF surgery related forms ONLY)
CD copy of procedure reports	$35 per CD
Medication Prior Authorization	$175 per Authorization, per Medication
Imaging or Lab study Prior Authorization	$230 per Authorization, per Study
Peer-to-Peer discussion for Prior Authorization	$400 per Authorization, per Peer-to-Peer
Physician Medical Letter Composition	$375 per Hour
Online patient portal messages	$75 - $150 per Occurrence

and other means of communication requiring the doctor/Nurse practitioner to respond may be charged (this service is not covered by your insurance plan).

Advanced Gastroenterology, Inc. hopes this will help your understanding of our Financial Policy and assist you in meeting any financial obligations in a timely manner. If you have any questions regarding our Financial Policy, please direct your questions to our Office Staff.

ADVANCED GI

Office Prior Authorization Policy

Our staff will no longer make calls to patients for any lab, imaging, pathology, or any other results. All results will be sent to patient either through the patient portal, encrypted email, fax, or our encrypted text messaging system. If you have questions or concerns regarding your results, you need to schedule an office visit or televisit to discuss your results with Dr. Simoni or the nurse practitioner.

For any emergencies, urgent, or life-threatening results that require immediate action, an office staff member, Dr. Simoni, or the nurse practitioner will contact you.

Our staff will not submit prior authorizations for any medications unless it is deemed necessary for a significant chronic condition or for select instances according to Dr. Simoni or the nurse practitioner. In these situations, our staff will make the patient aware of any fees associated with any prior authorizations and ask for the patient's permission to proceed. If a patient chooses to proceed with a prior authorization, we will collect the prior authorization fee in advance. Please see our financial policy below for the costs associated with prior authorizations.

Alternatively, our staff may have your prescription sent to a specialty pharmacy where they will submit the prior authorization and fill the prescription accordingly. Once approved, they will coordinate shipping to your home address.

Our staff will not submit prior authorizations for any imaging studies or lab studies. It is the responsibility of the imaging center and/or patient to request a prior authorization directly from the insurance carrier should one be necessary.

Patients are more than welcome to call to their insurance company and obtain the authorization forms. If patients choose to proceed in this manner, the patient may fill out these forms and send them to our office to complete and submit to the insurance carrier. However, in these situations, once our office staff becomes involved in this process, we will charge a $25.00 fee for every authorization form that is submitted to an insurance carrier.

Because the process of submitting authorizations to insurance companies can be a long and tedious process, this takes time away from assisting other patients with questions and concerns they may have. As a result, we reserve the right to charge a fee for every authorization that is initiated by our staff. For every authorization initiated by our staff, we will charge the following fees:

Medication prior authorizations	$175.00 per authorization per medication
Imaging study and lab prior authorizations	$230.00 per authorization per study
Peer-to-peer discussions for authorizations	$400.00 per authorization per peer-to-peer
Physician medical letter	$375.00 per hour

ADVANCED GI

Office Insurance Disclaimer

It is your responsibility to know your insurance benefits. When you enroll as a member of your insurance company, you are given an insurance membership handbook and insurance card. Please familiarize yourself with your handbook, with special attention to:

- In network provider
- Individual or family deductible amounts
- Waiting periods
- Benefits and plan maximums – example: if our fee is $500.00 and insurance maximum contracted/allowable fee is $400.00, insurance will pay a percentage of $400.00, not $500.00. The difference is your responsibility to pay.

You may also call the customer service number on the back of your insurance card and request the benefits department. Most insurance companies have a website where you can get information about your plan online. Every policy and plan is individualized. While several people may have the same insurance company, their specific policy will vary based on different benefits, and will pay different amounts according to their benefit schedule. One employer may have Anthem Blue Cross and may pay more than another employer with Anthem Blue Cross. Your plan all depends on the benefits package you have chosen.

The 2003 Health Insurance Portability and Accountability Act (HIPAA) regulation requires insurance companies to have disclaimers protecting individual information. This disclaimer also states that a reference number or authorization number for procedures is not a confirmation or guarantee of coverage or benefits. The coverage of benefits depends upon the individual contract terms, conditions, exclusions, and eligibility at the time services are rendered.

Our office requires a certain percentage of the cost of your procedure to be paid on the day of service. If your insurance pays more than what we estimate, we will refund you or apply the amount to your next office visit or televisit. If your insurance pays less than an estimate amount, you will be responsible and billed for the remaining balance.

It is important that you give us complete and accurate insurance information prior to your office appointment, exam, and/or procedure(s) and that you keep us informed of any changes. Please do not give us only a phone number and expect us to gather your information. We must have the insured members address, birth date, and employer, as well as a copy of the insurance card at the time of your office visit.

For your convenience, we will file an insurance claim with your insurance company. You may receive a statement from our office before your insurance has paid. These statements are to advise you of the status of your account. If your insurance company has not responded after 30 days, please take the time to call them and inquire on the status of the claim. Often, they require additional information from the member and the claim will not be processed until you provide them this information. Once the insurance payment is received, it will be reflected on your statement. If your insurance plan/policy determines a procedure to be “not covered” you will be responsible for the complete charge. Occasionally, your insurance may send a claim payment directly to the insured for services rendered by our office. In this instance, you will be responsible for the full amount of that check. If payment is not forthcoming within a reasonable time, the account and all pertinent information are forwarded to an outside collection agency for collection.

Our billing department is happy to assist you at any point during our billing cycle at 805-210-5491.