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 financially responsible for all charges resulting from the services provided by **Advanced Gastroenterology, Inc. (AGI)**. While we will bill most insurance carriers as a courtesy, you remain the **primary responsible party** for your account.

- **Copayments** are due **at the time of service**.
- Any remaining balance is due upon receipt of your **billing statement**, unless prior financial arrangements have been made.
- **Delinquent balances** over 90 days will be referred to a **collection agency**, with applicable **late fees or finance charges** added.

Minors: AGI does **not** provide pediatric gastroenterology services.

Insurance Billing

- It is your responsibility to provide **current and accurate** insurance information.
- If your insurance changes, you **must notify AGI prior** to receiving further care.
- If coverage is inactive or the plan does **not cover services provided**, you are **financially responsible** for the full amount.
- As a courtesy, we may **verify your insurance benefits**, but it remains your responsibility to confirm whether AGI is **in-network** at the time services are rendered.
- Please refer to the **AGI Insurance Disclaimer Notice** for further details.

Statements and Late Fees

- **Payment is due upon receipt** of your statement.
- A **$45.00 late fee** (subject to change without notice) may be assessed **per month** on past due balances **after 30 days**.
- All patients are responsible for any amount not covered by their **primary or secondary insurance**.
- We bill **secondary insurance** as a courtesy. If it denies payment, the **patient is responsible** for the unpaid balance.

For billing inquiries or to make a payment, please call our **Billing Department** at **(818) 294-7997**.

Medicare & Insurance Participation

- AGI **participates in Medicare** and will bill your **Medicare** and **supplemental insurance**.
- See Financial Responsibility for Services from the Out of Network Provider for our In/Out of network plans contracted.

Returned Checks: A **$100.00 fee** will be charged for any returned checks due to insufficient funds.

Authorization to Release Information: By signing below, you authorize AGI to:

- **Release medical information** to your insurance company, employer, union, or other entities involved in payment processing.
- **Share medical records** with referred providers for continuity of care.
- **Receive direct payment** of benefits for services rendered.

You acknowledge:

- You are financially responsible for **all charges**, regardless of insurance coverage.
- Unpaid balances **over 90 days** may be subject to **processing or collection fees**.

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 Cancellation Policy
(initials) _____ I have received Office Financial Policy.

(initials) _____ I have received Office Prior Authorization Policy
(initials) _____ I have received Office Insurance Disclaimer Notice

Who is the responsible Party? Name: _____ Relationship: ☐ Self ☐ Other: _____

PATIENT ATTESTATION

I, or my appointed agent, have read, understand, and agreed to the terms outlined above. I acknowledge that the information I have provided is true and accurate to the best of my knowledge. I understand that I am responsible for keeping information current and for all charges not covered by my insurance provider.

_____ _____ _____
PATIENT NAME PATIENT SIGNATURE DATE

Patient is _____ years of age and is unable to sign because of _____

_____ _____ _____
NAME AND RELATIONSHIP (IF NOT THE PATIENT) SIGNATURE (IF NOT THE PATIENT) DATE

ADVANCED GI

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: _____

ADVANCED GI

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: _____

Reason for appointment: _____ 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
- ❑ Surgical 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: _____

ADVANCED GI

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 stools ❑ 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

Out-of-Network Plans (Not Contracted):

Please check your current plan if it applies:

❑ Gold Coast
❑ Medi-Cal
❑ 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 Covered California plans*
❑ Anthem Blue Cross – Federal Plans *(federal plans typically begin with an "R")*
❑ International insurance plans

Patient Acknowledgment

I understand and acknowledge that **Advanced Gastroenterology, Inc.** and **Dr. Gilbert Simoni** are **not participating providers** with the health insurance plans listed above. I am choosing to receive treatment from Dr. Simoni and AGI as **an out-of-network provider** for my current insurance plan.

I further acknowledge the following:

- If my insurance coverage changes at any time during my treatment, I understand that AGI and Dr. Simoni **remain out-of-network** with the listed plans.
- I accept **full financial responsibility** for all charges incurred from services provided by AGI and Dr. Simoni.
- I agree to promptly respond to **any payment requests**, even if these services might have been covered in-network under a different plan or provider.

By signing below, I confirm that I fully understand the **financial implications** of receiving services from an out-of-network provider and accept responsibility for **any and all associated costs.**

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 about your insurance plan's network status, please contact your insurance company directly. To assist them, you may provide the following identifiers:

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

_____ _____ _____

PATIENT NAME PATIENT SIGNATURE DATE

Office Anesthesia Notice

Anesthesia Notice for Outpatient Procedures with Dr. Gilbert Simoni

This notice is for **all patients** electing to undergo **any outpatient procedure** with **Dr. Gilbert Simoni**.

Please be advised that **some health insurance plans do not cover Propofol (Diprivan) anesthesia** when administered by an anesthesiologist for routine endoscopic procedures. Instead, these plans may only cover **moderate (conscious) sedation**, which involves intravenous sedatives and opiates administered by the gastroenterologist **without the presence of an anesthesiologist**.

Important Disclaimers:

- **Advanced Gastroenterology, Inc. will not initiate or manage any prior authorization** process for anesthesia services.
- It is **your responsibility** to contact your health insurance provider to verify coverage for Propofol (Diprivan) anesthesia administered by an anesthesiologist.
- All **billing questions regarding anesthesia** must be directed to the **anesthesia group** providing the service on the day of your procedure.

Anesthesia Options & Cash Rates (If Not Covered by Insurance)- For procedures scheduled at Los Robles Medical Center (LRMC): Anesthesia Group: Conejo Los Robles Anesthesiology Medical Group, Inc.
NPI: 1821171729 | **Phone:** (805) 578-3904

Procedure Type	Cash Price
Single procedure	$350.00
Double procedure	$500.00
ERCP procedure	$550.00

For procedures scheduled at Advanced Digestive Center of Southern California (ADCSC):
Anesthesia Group: Tip Top Anesthesia - **NPI:** 1508283698 | **Phone:** (310) 779-3025

Procedure Type	Cash Price
Single procedure	$300.00
Double procedure	$450.00

Recommendation

We recommend patients consider receiving **Propofol (Diprivan)** anesthesia to avoid the discomfort and potential complications associated with local sedation. This option allows for deeper sedation and a more comfortable procedure experience.

Note: These discounted rates apply **only on the day of your procedure** and must be paid **directly to the anesthesia provider at the time of service**.

Acknowledgment

I acknowledge the following:

- I understand that **Advanced Gastroenterology, Inc. is not responsible** for billing or authorization of anesthesia services.
- I am aware that I must **contact my insurance provider** to verify anesthesia coverage.
- I understand that **any billing inquiries** related to anesthesia must be directed to the **anesthesiology group** providing the service.
- I have been informed of the cash price options available to me and that **payment for anesthesia is due on the day of service** if not covered by insurance.

See acknowledgement on the Insured Patient Payment Policy page.

Office Cancellation Policy

Cancellation & No-Show Policy

We understand that situations may arise in which you need to cancel or reschedule your appointment. If so, we kindly ask that you provide sufficient notice, as outlined below, to allow us to offer your time slot to another patient.

Cancellation Notice Requirements

- **Office Appointments:** Require at least **24 hours' notice** prior to the scheduled time.
- **FibroScan and Ultrasound Appointments:** Also require **24 hours' notice**.
- **Procedures:** Require at least **5 business days' notice** before the scheduled date.

Fees for Late Cancellations or No-Shows

- Office appointments cancelled with less than 24 hours' notice are subject to a **$75.00 cancellation fee**.
- FibroScan or ultrasound appointments cancelled with less than 24 hours' notice are subject to a **$75.00 cancellation fee**.
- Procedure cancellations with less than 5 business days' notice will incur a **$250.00 cancellation/no-show fee**.
- Patients who **do not show up** for an office or procedure appointment without prior notice will be considered a **No-Show** and charged the applicable fee.

Repeated No-Shows

- Patients who **No-Show two (2) or more times within a 12-month period** will be **dismissed from the practice** and denied future appointments.

Financial Responsibility

- Cancellation and No-Show fees are **the sole responsibility of the patient**. These fees are **not covered by insurance** and must be **paid in full before the next appointment**.

Exceptions

We understand that certain **unavoidable circumstances** (e.g., illness, death in the family, natural disasters) may arise. In such cases, fees may be waived **only with management approval**.
At Advanced Gastroenterology, Inc., we believe that a strong physician-patient relationship is built on transparency, mutual respect, and open communication.
For any questions about this policy, please contact our **Office Manager at (805)719-0244**.

See acknowledgement on the Insured Patient Payment Policy page.

Office Financial Policy

To ensure transparency and avoid misunderstandings, please carefully review our financial policy:

Insurance & Payment Responsibility

- A **current insurance card** must be presented at the time of your visit. If not, **payment in full is required at the time of service**.
- As the **purchaser/beneficiary** of your insurance policy, you are ultimately responsible for understanding your policy, including:
  - Whether your insurance plan is in-network with Advanced Gastroenterology, Inc. (AGI)
  - Your out-of-pocket responsibilities such as **co-pays, co-insurance, and deductibles**
  - What services does your insurance cover and does not cover

Important: Even if AGI is listed as an in-network provider, some insurance plans may still process your claim as **out-of-network** based on specific policy terms—**without our prior knowledge**.

Our staff may attempt to verify your coverage as a **courtesy**, but insurance companies often issue disclaimers such as **"no guarantee of payment"** until a claim is fully processed.

Due Diligence Encouraged

We strongly encourage you to **contact your insurance provider directly** to verify:

- In-network or out-of-network status
- Coverage of specific procedures and services
- Patient financial responsibilities

You are responsible for any balance not covered by your insurance.

Outside Testing Facilities

Some tests or procedures may be performed at centers **not contracted** with your insurance plan. Our staff may not be aware of these contractual details.

Please note: **Advanced Digestive Care of Southern California (ADCSC)** is currently **only contracted with Anthem Blue Cross** and **no other insurance providers**.

If AGI or its providers are out-of-network:

- **Payment in full is due at the time of service**
- As a **courtesy**, we will still submit your out-of-network claim to your insurance carrier

Payment Expectations

We expect payment at the time of service for:

- Co-pays
- Estimated co-insurance and deductibles
- Non-covered services
- Any outstanding balances

If needed, please discuss **payment arrangements** with us in advance.

Administrative Fees

The following are **non-refundable** fees for administrative services:

Service	Fee
Medical or billing record copies	$35 (up to 25 pages); $0.25 per additional page*
Completion of Work/Disability/FMLA forms (TIF-related only)	$45*
CD copy of procedure reports	$35 per CD*
Medication Prior Authorization	$175 per medication*
Imaging or Lab Study Prior Authorization	$230 per study*
Peer-to-Peer Discussion for Prior Authorization	$400 per occurrence*
Physician Medical Letter Composition	$375 per hour*
Online Patient Portal Messages**	$75–$150 per occurrence*

*All fees are subject to change without notice.

**Portal messages requiring a medical response may be billed to the patient if not covered by insurance.

We hope this policy helps clarify your financial responsibilities and supports a smooth experience at our practice.

For questions, please contact our **Office Staff**.

See acknowledgement on the Insured Patient Payment Policy page.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

ADVANCED GI Inc

Results Communication Policy

To protect your privacy and ensure timely access to your health information, **our office no longer makes phone calls** to discuss lab, imaging, pathology, or other test results. Instead, results will be delivered to you through one of the following secure methods:

- Patient portal
- Encrypted email
- Encrypted text messaging system
- Fax (if requested)

If you have questions or concerns about your results, please **schedule an in-person visit or televisit** with Dr. Simoni or the Nurse Practitioner.

Note: For **urgent or life-threatening results** that require immediate action, you will be contacted directly by a staff member, Dr. Simoni, or the Nurse Practitioner.

Prior Authorization Policy

To ensure efficient care and responsible use of staff time, our prior authorization process follows strict guidelines:

Medications

- Prior authorizations for medications will **only be submitted** if deemed medically necessary for a **significant chronic condition** or in **select cases**, as determined by Dr. Simoni or the Nurse Practitioner.
- If approved, patients will:
    - Be **informed of the applicable fee**
    - Be **required to provide consent** before proceeding
    - Have the **authorization fee collected in advance**

Alternative Option: When possible, we may forward your prescription to a **specialty pharmacy**. These pharmacies typically handle the prior authorization process and arrange home delivery once approved.

Imaging & Lab Studies

- We **do not submit prior authorizations** for imaging or lab studies.
- It is the **responsibility of the imaging center and/or patient** to request prior authorization from the insurance carrier, if required.

Patients may also:

- Contact their insurance company directly to request prior authorization forms.
- Fill out the forms and submit them to our office for completion.

If our office is involved in submitting these forms, a **$25.00 administrative fee** will be charged **per authorization form**.

Prior Authorization Fees

Due to the administrative burden and time required, the following **non-refundable fees** apply for each prior authorization initiated by our staff:

Service	Fee
Medication Prior Authorization	$175.00 per medication*
Imaging or Lab Study Authorization	$230.00 per study*
Peer-to-Peer Discussion	$400.00 per authorization*
Physician Medical Letter	$375.00 per hour*

*All fees are subject to change without notice. To the best of our knowledge, these fees are **not covered by any insurance plan**.

At Advanced Gastroenterology, Inc., we strive to balance high-quality care with efficient service. We appreciate your understanding and cooperation with our policies.

For any questions, please contact our **Office Staff (805)719-0244**.

See acknowledgement on the Insured Patient Payment Policy page.

Office Prior Authorization Policy

To ensure the efficient use of staff time and to uphold the highest quality of care, please review our policy regarding test results and prior authorizations:

Test Results Communication

- **Routine lab, imaging, pathology, or other test results** will **not be communicated via phone**. Results will be delivered through one of the following secure methods:
  - Patient portal
  - Encrypted email
  - Encrypted text message
  - Fax (if requested)
- If you have **questions or concerns** about your results, please **schedule an office or telehealth visit** with Dr. Simoni or the nurse practitioner to discuss them in detail.
- In the event of **urgent, emergent, or life-threatening results**, a staff member, Dr. Simoni, or the nurse practitioner will contact you **directly and promptly**.

Prior Authorization Policy

Medications

- We **do not submit prior authorizations** for medications unless they are:
  - Required for a **significant chronic condition**, or
  - Deemed medically necessary **at the discretion of Dr. Simoni or the nurse practitioner**
- In such cases:
  - Our staff will **inform you of any associated fees** and obtain your **permission** before proceeding.
  - If you agree to proceed, **payment is required in advance**.
  - Alternatively, prescriptions may be routed to a **specialty pharmacy**, which may handle the authorization and delivery to your home.

Imaging & Lab Studies

- AGI **does not submit prior authorizations** for imaging or lab studies.
  - It is the **responsibility of the imaging center** or the **patient** to obtain authorization from the insurance carrier.
  - Patients may also request authorization forms from their insurance provider, complete the patient portion, and submit them to our office for completion and submission.
- In such cases, once AGI staff becomes involved, a **$25.00 fee will be charged per authorization form** submitted.

Authorization Fees

Due to the extensive administrative time required, the following fees apply when AGI initiates any prior authorization:

Service	Fee
Medication Prior Authorization	$175.00 per medication*
Imaging or Lab Study Prior Authorization	$230.00 per study*
Peer-to-Peer Discussion	$400.00 per authorization*
Physician Medical Letter	$375.00 per hour*

*All fees are subject to change without notice.

To the best of our knowledge, **none of these fees are covered by insurance**.

We appreciate your understanding and cooperation. These policies help us better serve all patients in a timely and respectful manner. If you have questions, please contact our **Office Staff**.

See acknowledgement on the Insured Patient Payment Policy page.

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Office Insurance Disclaimer Notice

Understanding your insurance coverage is essential to avoiding unexpected costs. As a patient, it is **your responsibility** to be familiar with the details of your insurance plan.

Know Your Benefits

Upon enrollment with your insurance carrier, you receive a **membership handbook** and **insurance card**. Please review them carefully, with particular attention to:

- In-network vs. out-of-network providers
- Individual and family deductibles
- Waiting periods
- Plan benefits and maximum allowable charges

Example: If our fee is $500.00 and your insurance plan allows only $400.00, the insurance company will pay a percentage of the $400.00—not $500.00. The remaining difference is your financial responsibility.

Every insurance policy is **unique**. Even patients with the same carrier (e.g., Anthem Blue Cross) may have **different coverage levels** based on employer agreements or individual plan selections.

You may call the **customer service number** on the back of your insurance card or visit your carrier's website to get detailed information specific to your plan.

HIPAA & Insurance Disclaimers

Under the **Health Insurance Portability and Accountability Act (HIPAA) of 2003**, insurance companies are required to protect your information and provide disclaimers. These disclaimers typically state:

- A reference number or authorization is **not a guarantee of payment**
- Final coverage decisions depend on the policy's **terms, conditions, exclusions, and eligibility at the time of service**

Procedure Estimates & Payments

Our office requires partial **payment** on the day of your procedure based on our estimate of your coverage. After insurance processes the claim:

- If they pay **more** than estimated: You will receive a refund or a credit toward your next visit.
- If they pay **less** than estimated: You will be **billed for the remaining balance**.

Insurance Information Requirements

Please provide **complete and accurate insurance information** before your visit or procedure. This includes:

- Insurance card copy
- Insured member's full name, address, birthdate, and employer

Important: Please do not provide just a phone number—we cannot verify the benefits without full information.

Insurance Claim Filing

As a courtesy, we **submit claims** to your insurance company. However:

- You may receive a statement from us **before your insurance has paid**. This is informational only.
- If your insurance has not responded **within 30 days**, please contact them directly. Delays often result from missing information only the member can provide.

If your insurance determines that a service is **"not covered,"** the full cost of that service will be **your responsibility**.

In some cases, your insurance may send payment **directly to you** for services rendered by our office. If this occurs, you are obligated to **sign the check-over to us** or submit **payment equal to the amount received**.

Non-payment: If we do not receive payment within **90 days**, your account will be referred to a **collection agency**, and additional **late fees or finance charges** may apply.

We're Here to Help

If you have questions at any point during the billing cycle, please contact our **Billing Department** on **(818) 294-7997**.

See acknowledgement on the Insured Patient Payment Policy page.