3601 NE Ralph Powell Road
Lee's Summit, MO 64064
816.836.2200 | f 816.836.2244
Midwestgihealth.com

FINANCIAL & OFFICE POLICIES

Thank you for choosing Midwest GI Health as your health care provider. We are committed to building a successful physician relationship with you and your family. Your clear understanding of our Patient Financial/Office Policies re important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about out fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes.

Co-pays - The patient is expected to present an insurance card at each visit. All co-pays and past due balances are due at time of check-in unless prior arrangements have been made with the billing office. We accept cash, checks, debit or credit cards. (No post-dated checks **will** be accepted).

Insurance Claims - Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your insurance company as a courtesy and as a group, are contracted with many insurance companies including Medicare. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance information. Patients are responsible for maintaining current personal contact and insurance information with our office. Outdated information is a significant reason Insurance companies deny claims. Denied claims are due and pay<!ble by the patient. It is your insurance company that will makethe · final determination of your eligibility and benefits.

Private or Self Pay- Private/self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. These accounts are-responsible for payment at the time of service and prior to any,procedures that are scheduled.

Returned checks - The charge for a returned check is $35.00 payable by cash, money order or credit card. This will be applied to your account in addition to the insufficient funds amount.

Authorization to Release Information - *In obtaining payment for services, I authorize Midwest GI Health to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including *my* insurance companies and their representatives and my employer or union if they are involved in processing the claim. For further information regarding disclosure of health information please refer to the Notice of Privacy Information. *If I have been referred by, or am being referred to another healthcare provider, I authorize Midwest GI Health to release my medical information to this provider for continuing care. *I hereby authorize payments of benefits to Midwest GI Health. I understand that I am financially responsible for all charges incurred in the course of my treatment by Mid_west GI Health.

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:·

PATIENT NAME _____ **PATIENT SIGNATURE** _____ **DATE** _____

***Signature if Disclosure of Information if NOT Authorized and I agree to pay for the costs of all treatment and services personally:**

PATIENT SIGNATURE. _____ **DATE.** _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM. I, _____ have been offered and/or received a copy of the Notice of Privacy Practices.

PATIENT SIGNATURE _____ **DATE** _____

Midwest GI Health

3601 NE Ralph Powell Road
Lee's Summit, MO 64064
816.836.2200 | f 816.836.2244
Midwestgihealth.com

NO SHOW/CANCELLATION POLICY

Thank you for trusting your medical care to Midwest GI Health. When you schedule an appointment with Midwest GI Health we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible. This policy is created to increase our ability to respectfully care for all patients in a professional and timely manner, by offering open appointment times to patients who are in need.

Patient requirements:

Patients unable to make their scheduled appointment/procedures are required to notify our office by calling 816-836-2200 as follows:

- Four (4) business days' notice if unable to keep a scheduled procedure or infusion appointment
- Two (2) business days' notice if unable to keep a scheduled office visit

Patients are responsible for maintaining current personal contact and insurance information with our office. Please review this information on each visit.

Midwest GI Health Guidelines:

- As a courtesy, when time allows, we make a reasonable effort to confirm scheduled appointments, however, patients are responsible for the times they have chosen whether they receive a reminder or not.
- Any patient arriving more than 10 minutes late for their scheduled appointment will be considered a No Show
- Appointments not cancelled by the policy guidelines above are billed as follows:
- $35.00 for an office visit
- $100.00 for a procedure or infusion appointment.
- Insurance companies DO NOT pay cancellation fees.
- Patients are not rescheduled until No Show fee(s) are paid.

Please return this form with your signature, name and the date prior to your scheduled appointment/procedure.

I have read and understood the above policy and agree to abide by the guidelines as outlined, pay any fees I incur, and any additional fees incurred in the attempt to collect unpaid debts.

Patient Signature X_____ **Date**_____

Patient Name_____ **Date of Birth**_____

Telephone Number_____

mwgi Midwest GI Health

MIDWEST PHYSICIANS SURGERY CENTER

HIPAA ELECTRONIC INFORMATION CONSENT

I consent to the use of my contact information and email for the purposes of receiving health related material and/or electronic information including a patient survey from Midwest GI Health.

When you receive your survey please feel free to include any feedback regarding our office, services we provide, or any staff members you may have encountered during your visit. We welcome your input to ensure we continue to serve our patients with the highest standard of care.

I understand that this is strictly voluntary. I may revoke this authorization at any time in writing, but if I do, it will not have an effect on any actions taken prior to receiving the revocation.

Email: _____

Signature: _____ Date: _____

Printed Patient Name: _____ MRN#: _____ (office use only)

3601 NE RALPH POWELL ROAD • LEE'S SUMMIT, MISSOURI 64064 • PH (816) 525-4440 • FX (816) 246-9887