Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

Financial Policy

Thank you for choosing Northwest Gastroenterology Clinic, LLC and NGC Endoscopy Services, LLC for your healthcare needs. We are committed to providing you with the best possible medical care. Prior to your scheduled appointment, please call your insurance company for your benefit coverage. The following information outlines your financial responsibilities related to payment for professional services.

ALL PATIENTS

Patients are responsible for any charges incurred on the account resulting from treatment provided. Any balance due must be paid 30 days from the date of service, unless you have contacted our billing office (503-229-7461) to make payment arrangements.

- **Returned Checks**

A $35.00 charge will be added to your account for any check returned by your bank for any reason. This will be in addition to charges made by your bank.

- **No show/ Canceled/ Rescheduled Services**

As a specialty provider our office visits schedule several weeks out, we also perform a large volume of procedures which require considerable time and resources to perform. Please be considerate of your fellow patients and our office staff and allow at least 2 days notice for cancellations of office visits and 3 days for procedures. Our office reserves the right to charge patients that do not provide us with the appropriate notification in cancelling the appointment. Our policy is to charge $50.00 for missed office visits and $100 for missed procedures.

- **Collections**

We utilize a collection agency for past due/unpaid accounts over 60 days from the date of service or last payment received. If there are any issues with your account, please contact our office with questions and/or concerns. If there was an insurance issue that was not discussed or resolved prior to your account going to collections, you are responsible for the bill.

INSURED PATIENTS

As a courtesy, our office will bill your primary and secondary insurance for you. We cannot bill your insurance company unless you give us your correct insurance information. Please understand that your medical insurance is a contract between you and your insurance company. We are not party to that contract. Patients are responsible for knowing their coverage limitations and benefits. The billing office cannot guarantee payment for services or quote benefits from your health plan.

- **Referrals and Pre-Authorizations**

Our billing office will attempt to obtain a referral or pre-authorization if your plan requires one. If you choose to be seen prior to receiving the referral or authorization, your insurance may not pay for your appointment.

- **Procedures**

If you receive services in NGC Endoscopy Services, LLC you will receive a bill with a charge for the facility and a charge for the physician's time. You may also receive separate bills for anesthesia and any laboratory or pathology services. If your procedure is performed in the hospital you will receive separate bills from the hospital.

- **Helpful Information**

You are responsible for your bill whether your insurance pays or not. To assist you in finding benefit coverage for your plan, call your insurance company with the following information: Northwest Gastroenterology Clinic, LLC (physician) tax ID 930884808; NGC Endoscopy Services, LLC (facility) tax ID 931307280. For questions concerning anesthesia billing or charges, please call Complete Anesthesia Care 1-888-819-7818.

UNINSURED PATIENTS

Patients without insurance will be required to make a deposit at the time of service. New patients are required to bring $250; established patients $85; and scheduled procedures are $1500. If there is a balance remaining you will receive a statement.

AUTHORIZATION

- I authorize Northwest Gastroenterology Clinic, LLC and NGC Endoscopy Services, LLC to submit claims for benefits without obtaining my signature on each and every claim.
- I authorize my insurance(s) benefits to be paid to Northwest Gastroenterology Clinic, LLC or NGC Endoscopy Services, LLC

- I have read, understand and agree to the provisions of this Patient Financial Responsibility Form:

Responsible signature:_____ Date: _____