west valley
colon & rectal surgery center, llc

Financial Agreement

We, the staff of West Valley Colon and Rectal thank you for choosing us as your medical provider. We consider it a privilege to serve your colorectal needs and we look forward to doing so professionally, sympathetically, and civilly. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship. Our goal is not only to inform you of the provisional aspect of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact Adriana, Practice Administrator, at (623)875-7330 extension: 110.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (debit card, money orders, MasterCard, Visa, Personal Checks, and all forms of credit cards). A $35.00 fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we may adhere to the highest level of information security.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance for clarification from anyone within our business.

Sincerely,
West Valley Colon and Rectal Surgery Center, LLC

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Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is the patient's responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information, coordination of benefits, or secondary insurance plans, and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obliged to collect on all copayments, coinsurance, and deductibles, as outline by your insurance carrier.

It is my responsibility all current insurance information at each visit. Including my up-to-date insurance card(s) and information. I understand that I am responsible for all remaining balance(s) after my insurance has paid on my claim immediately upon receipt of a statement.

Out of Network

It is your responsibility to ensure that our providers and practice is in network with your insurance carrier. Please be aware that out of network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in filing an appeal if these limitations are imposed, you as the guarantor are fully responsible for all out-of-network fees. If we are not contracted with your carrier, we will not be negotiated reduced fees with you or the insurance carrier.

Insurance Information

I agree to provide West Valley Colon and Rectal Surgery Center, my complete and accurate insurance information for primary and secondary, etc insurance benefits, including referral documents from other providers if required by my plan(s).

I understand that if I fail to give complete and accurate information about my insurance benefits, this may result in a denial of claim or delay in payment. I agree to pay West Valley Colon and Rectal the balance on my account after my insurance has processed.

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Workers Comp/Work Related Injuries

If the reason for my visit is related to a work-related injury or auto accident, I agree to provide WVCRSC the case number or policy number, the workman's compensation or insurance carrier name, address, or other information necessary to file the claim. If I do not provide this information as the time of service, I agree to pay all charges for my visit.

High Deductible Plans

If I have a high deductible policy or do not have insurance benefits. I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

I agree to pay all applicable co-payments, co-insurances and/or deductibles at the time of service. Otherwise, I will have to reschedule my appointments. By law, our office is obligated to collect on all applicable copays and deductibles.

Mailing Address/Correspondences

I understand that it is my responsibility to provide my current address and mailing address to avoid any delay in statements, West Valley Colon and Rectal will charge a $35.00 fee for all returned mail items.

Delinquent Account

Your account will be considered delinquent after 90 days post the first statement.

Collections

I understand that if my account becomes delinquent, it will accrue a $50.00 collection fee on top of my original balance. It may be forwarded to an outside collection agency. If this happens, I will be responsible for all costs for collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs

FMLA/Short Term Disability Paperwork:

There is a $45.00 charge to be complete all requests. Payment is due in full prior to the form being completed. Additional requests will be charged $25.00. WVCRSC has up to 14 business days to complete.

Missed Appointments

I understand that I will be responsible for missed office visits or any cancelled appointments in which a 24-hour notice was not given. There will be a $45.00 charge.

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No Show

There will be a $45.00 charge for all appointments that I no show to. After three no shows you are subject to dismissal from the practice.

Patient Balances

All patient balances will be communicated to the patient as soon as the claim has processed, and insurance has paid. This will be done via telephone, patient statements, before your office visit, or prior to rendering additional services. Patient balances must be up to date and paid in full prior to rendering any additional services including preventative care, in office visits, procedures, and surgical services.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information, and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies, including the copying, supplies, labor, and postage of the files, and or summaries.

Surgical and Colonoscopy Procedures

Our office will verify and check benefits prior to any scheduled surgical procedure. Our office will collect on our allowed amount and patient's financial responsibility up front prior to the services be rendered. Patients will be subject to all copayments, deductible, coinsurance, and out of pocket as advised by your insurance carrier.

I understand that if I fail to show for my colonoscopy procedure a $100 fee will be charged to my account. I will not be rescheduled until this fee is paid in full. This fee will not apply to my current colonoscopy estimate and will NOT be billed through your insurance.

I understand that all colonoscopies are not considered preventative. We as a courtesy, will check your benefits. If at any time your insurance deems your procedure as non-preventative you will be subject to all applicable copays, co-insurances, and/or deductibles. It will be my responsibility to pay for my procedure.

I understand that if I fail to show up for my surgical procedure a $300 fee will be charge to my account. This fee will not apply to my current surgical estimate and will NOT be billed through your insurance.

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I have read and understand WVCRSC financial policies, and I accept full responsibility for the payment of any fees associated with my care. I understand that this a legal binding contract between West Vally Colon and Rectal Surgery Center and you. The words, I, me, my, you, and your all refer to the patient.

Patient Name (printed): _____

Patient Signature: _____

Date: _____

If you do not agree to sign this form, our Practice may reserve the right to refuse services to you. We believe in a clear communication and have provided our outlined policies above.

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