Patient Registration, Consent for Treatment

Financial Policy Form

Welcome and thank you for choosing Rochester Colon Rectal Surgeons, P.C. for your medical care. This patient financial policy has been developed to help our patients understand their financial responsibilities regarding their healthcare benefits. Please review and sign our treatment, office and financial policies.

- I hereby give consent for treatment of myself, or the named minor child, by the physician, physician assistants, nurse practitioners, and/or staff of Rochester Colon Rectal Surgeons, P.C. (RCRS).
- I am responsible for providing RCRS with **correct insurance information** at the time of my appointment. If my plan changes, I need to notify the office of these changes. If I fail to do so, I will be responsible for any charges that are not paid in full.
- I am required to obtain a referral from my primary care physician if my insurance requires one. If a referral is required, and I do not have one at the time of service, **I will be financially responsible for the services I received – payment in full.**
- I am responsible for any copay, co-insurance, or deductibles required by my insurance company. I am responsible to know how much my copay is. Payment will be collected at the time of service. Payment of **$75 TOWARD my deductible or copayment** unless otherwise specified will be collected at the time of service. Some services may be billed to my insurance company prior to collecting for services. If I owe RCRS it is my responsibility to make prompt payment. I am fully responsible for any unpaid account balances including, but not limited to, co-payments, co-insurances, and deductibles not paid by my insurance carrier. I understand that I will be charged an administrative fee of $20 if I do not pay at the time of service. Accounts not paid in full within 30 days will be subject to a finance charge of up to 18% annually. Should my account become delinquent after 90 days I will be referred to the collection agency; I am responsible for the balance owed plus all the costs incurred in collecting the balance. Please be advised that in the event there are any outstanding balances, we may refuse treatment and/or to schedule an appointment for you. **We review delinquent accounts for dismissal. Delinquent accounts are defined as accounts with unpaid balances 90 or more days past due**.

OFFICE PROCEDURES:

As a colorectal specialist, it is very likely that the provider will perform a diagnostic procedure essential in managing your medical condition. These procedures are known as anoscopy, proctoscopy, and/or flexible sigmoidoscopy. Your insurance carrier may define them as a "surgical procedure." Your explanation of benefits may reflect the use of this term and you may be charged an additional copayment or deductible for these procedures.

TYPES OF COLONOSCOPY:

- Diagnostic/Therapeutic Colonoscopy: patient has past and/or present gastrointestinal symptoms, polyps, or gastrointestinal disease.
- Surveillance/High Risk Screening Colonoscopy: patient is asymptomatic (no gastrointestinal symptoms either past or present) or has a personal history of gastrointestinal disease, colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals.
- Preventative Screening Colonoscopy: patient is asymptomatic (no gastrointestinal symptoms either past or present), is 50 years or older, has no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years.

***** ***NOTE*** Having had a colonoscopy in the past makes a difference in coverage by your insurance for any future colonoscopies. If you have a colonoscopy before insurance guidelines allow (ex: procedure performed 59 months from

the original colonoscopy date, however the insurance policy states that it must be at least 60 months) and RCRS is unaware of this, **YOU WILL BE RESPONSIBLE FOR THE FEES ASSOCIATED WITH THE PROCEDURE.**

SELF-PAY Payment is expected at the time of service. An estimate will be given of the charges prior to your visit and will require a minimum payment at the time of service. This minimum payment **MAY NOT** cover all services rendered. ***Please note that these fees represent a courtesy discount for paying at the time of your visit. If for any reason you do not pay at the time of service, you will be billed the standard rates.***

- **New Patients** (including those who have not been seen in over 3 years) - **$285**
- **Follow up visit/service** – **$210 each** (balance billing post visit)
  - **Depending on the recommended course of treatment, you will be billed for any other procedures that occur during the visit, not covered by the above stated charges.**
- **Surgical Procedures** – 50% of the surgery will be collected before the time of service. The remainder of the balance will be mailed in your statement for payment. If you have any questions or need assistance, please contact the billing department at 585-244-5670 (option 4).

- I understand that the cancellation policy for appointments at RCRS is that I must contact the office **2 business days prior** to my appointment to avoid the **$75 missed appointment fee**. If I have missed appointments I may be dismissed from the practice.
- I understand that the cancellation policy for surgical procedures (surgery/colonoscopy) is that I must contact the office **4 business days** prior to the surgery date to avoid the **$150 missed appointment fee**. If I have missed appointments I may be dismissed from the practice.
- Returned checks are subject to a $40 service charge and will terminate my privilege to pay by check for future visits.
- I understand that it is my responsibility to call my insurance company to know what **my insurance plan benefits cover or who is in my network**. I will call the insurance company to educate myself on what labs, imaging or hospitals I am eligible to get services from and the possible copayments or deductibles that I am financially responsible for.

ASSIGNMENT OF BENEFITS: I understand that my records in their entirety, regardless of coverage, may be released to any government agencies (Medicare, Medicaid, subpoena) or insurance companies for the purpose of pursuing payment, reimbursement, submitting claims for services rendered or to be rendered to me, or performing quality assurance reviews as required by law.

We accept Cash, Check and credit VISA, MC and Discover and all HSA/FSA cards.

BY SIGNING BELOW: I have read the entire page(s) above which explains my patient financial responsibility. I agree to the above terms, to be financially responsible for the amounts determined by my insurance company and/or RCRS. By signing this I agree to be personally and fully responsible for payment.

ELECTRONIC SIGNATURE WILL BE OBTAINED AT TIME OF VISIT

Patient/Legal Representative PRINT and SIGN **Relationship to patient** **Date**