Patient Financial Responsibility/ HIPAA notification/Disclosures

Patient name: _____Date of birth:_____

I. Financial Policy

This is a statement of Estrella Gastroenterology (Estrella GI) financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. You agree that you will pay any deductible ,co-payment, and/or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance. Non-payment of balances may be turned over to collections or small claims court for action.

II. No Show/Cancellation Policy

Estrella Gastroenterology (Estrella GI) requires a *minimum* of **24-hour notice** from our patients when canceling or rescheduling an appointment. Failure to cancel/reschedule before the 24 hour window may result in a **$35 FEE** per missed office visit and **$100 FEE** per missed procedure/no show per infraction (payable upon receipt of billing). Telephonic/email appointment reminders are made by our staff when time permits. However, it is ultimately your responsibility to remember scheduled appointments. You may leave notice of cancellations/re-schedules via phone **623-935-4056**, but it must be at least 24 hours in advance of the appointment. Please assist us in maintaining good service through efficiency.

III. HIPAA (Health Insurance Portability and Accountability Act of 1996)

We disclose your protected health information to carry out treatment, payment, and health care operations. If you would like a more detailed description of such uses and disclosures, please refer to the *Notice of Privacy Practices*. You have the right to review the *Notice of Privacy Practices* before signing this consent form. The terms of the *Notice of Privacy Practices* may change from time to time. You can get a copy of the latest *Notice of Privacy Practices* by contacting our office. We also will post a copy of our current *Notice of Privacy Practices* in our office. You have the right to request that we restrict how we use or disclose protected health information to carry out treatment, payment, or health care operations. We do not have to agree to such requests, but must honor the requests to which we agree. You have the right to revoke this consent in writing, and the revocation will become effective except to the extent that we acted in reliance on your consent.

IV. SELF PAY

Self pay/non-insurance patients are expected to pay for office visits in full at the time of service. Any monies for procedures must be paid at least 3 days prior to the procedure date. If you are unable to pay the amount in full, you must speak to the office manager.

My Acknowledgment : I have read and understand the financial and no show/cancellation policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

_____ _____

Patient or legally authorized *individual* signature Date