Digestive Health Associates of Reno

655 Sierra Rose Drive
Reno, Nevada 89511
Phone (775) 829-7600
Billing 1-866-978-6912
Fax (775) 829-3757
www.digestivehealthreno.com

Acct#_____

PATIENT FINANCIAL PARTNERSHIP AGREEMENT

1. We bill our patient's insurance as a **COURTESY**. Therefore, it is the **RESPONSIBILITY OF EACH PATIENT** to provide us with current and accurate insurance information. For us to bill your insurance we must have your insurance information prior to your office visit or procedure in order to get any required authorizations. Failure to do so may result in your care being delayed or denied by your insurance carrier or you being billed-directly for services rendered.
2. **All co-pays/fees will be collected at time of service.**
3. Based on what office your care is provided, you may receive **statements** from **Digestive Health Associates, Northern Nevada Endoscopy Center** and/or our **Pathology Facility**. Each of these entities may bill you directly or indirectly associated with your care from our office practice or center.
4. If payment from your insurance carrier is not received **within 60 days of filing your claim**, you may be billed for the entire amount of the charges. Once our office has received payment from your insurance carrier(s), you will be billed for any remaining patient responsibilities (e.g. co-payments, deductibles, co-insurance). Any balance that is not paid within 60 days of receiving a bill from our office will be sent to collections.
5. For uninsured patients, office visit payment is due in **FULL at the time of service**. Payment for a procedure is due in **FULL 3 days prior to the time of service.**
6. There is a $35 charge to complete all forms including but not limited to FMLA, disability, worker's compensation, legal documentation, etc.
7. There will be a charge of $.60/page per Nevada State Law for copies of any medical records/PHI. See NRS 629.061.
8. To better serve your needs we're using Next Services to handle all of your billing. They may reach out to you with questions about your account. You may contact them at 1-866-978-6912 for any questions or concerns regarding your account.

DHA accepts Debit, MasterCard, Discover,VISA and American Express for your convenience for all rendered services.

Should you have any questions regarding these policies, please call the Business Office at 1-866-978-6912.

Patient or legal guardian signature_____ Date _____

APPOINTMENT Cancellation/No-Show Policy

Should you need to cancel your appointment for your **office visit**, you are required to provide the office with a 1 business (24 hour) day notice. Failure to do so or you are a "no-show", defined as missing your scheduled appointment without notification to the office, will result in a $50 charge. ***You will be required to pay in full prior to scheduling your next appointment.***

PROCEDURE Cancellation/No-Show Policy

Should you need to cancel your appointment for your **procedure**, you are required to provide the office with 2 business (48 hour) day notice. Failure to do so or you are a "no-show", defined as missing your scheduled procedure appointment without notification to the office or procedure center, will result in a $100 charge. **You will be required to pay in full prior to scheduling you next appointment.**

Any combination of 3 untimely cancellations and/or no-shows will result in your being discharged from the practice and/or procedure.

I have reviewed and agree to comply with the Office and Procedure (if applicable) Appointment Cancellation/No-Show Policy.

Patient Name (Please print name): _____

Patient Signature: _____

Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Due to HIPAA privacy laws we cannot discuss any aspect of your care with anyone unless we have your permission. This includes making appointments, obtaining prescriptions, test results, or even acknowledging your are a patient here. Please list below any person(s) you would like to allow to receive your health information.

I, _____ authorize the physicians and staff of Digestive Health Associates to release my protected health information to the following:

Name_____ Relationship_____ Phone Number _____

Name_____ Relationship_____ Phone Number _____

_____ **I do <u>not</u> wish to allow anyone to receive my protected health information.**
initials

_____ **I acknowledge that Digestive Health Associates may contact your pharmacy for medication history.**
initials

Patient or legal guardian signature_____ Date _____

ACKNOWLEDGMENT:

- I acknowledge that I have received access to the "Notice of Privacy Practices" for Digestive Health Associates. I have read and understand the "HIPAA & Release of Medical Information Policy".
- I hereby authorize Digestive Health Associates to release any information requested by the insurance company or companies or respective representatives and act as my agent to secure payment from any and all services rendered.
- I understand that I am financially responsible to the physician for any and all charges incurred by myself and/or dependents.
- I further acknowledge and understand that I accept the terms outlined in each of the policies.
- I understand that no warranty or guarantee has been made to me relative to result in care or medical outcome.

X _____ _____
Patient or Guardian Signature Date