Colorectal Health Northwest

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Northwest Center for Colorectal Health (NWCCH), LLC as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
  - Charge for returned checks
  - Charge for missed appointments without 24 hours notice
- By my signature below, I hereby authorize assignment of financial benefits directly to NWCCH, LLC and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize NWCCH, LLC personnel to communication by mail, phone, and/or voice mail message, according to the information I have provided below:

Please read and then choose YES or NO:

- If you are unavailable, may we leave medical information from NWCCH, LLC office, such as normal blood test results or normal biopsy reports on your voice mail or with someone at your residence?
  _____YES – you may leave information as above
  _____NO – do not leave any information with anyone

If yes, please list name and relationship of person(s) we are authorized to discuss your medical care and/or account:

_____ _____

Name Relationship Name Relationship

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

Signature of Patient or Guardian Date