



HIPAA Acknowledgement and Consent

I understand that Colorectal Health Northwest, LLC (referred to as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be reviewed from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of This Practice's Notice of Privacy Practices in effect will be available in the reception area.

I understand that I have the right to ask that some or all of my information not be used or disclosed in the manner described in the Notice of Privacy Practices and understand that This Practice is not required by law to agree to such requests.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice. **The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).**

I understand I may receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information, and that I may opt-out of receiving emails and text messages by submitting a request in writing.

By signing below, I agree that I have reviewed and understand the information above and that I can receive a copy of the Notice of Privacy Practices if I request one.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship to Patient

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

Insurance: Colorectal Health NW (NWCCH) participates with Medicare, Medicaid, and many Commercial insurances and agrees to file claims with your primary and secondary insurance as a courtesy to you. By doing so, your insurance will remit payment for benefits directly to NWCCH and any ineligible or non-covered expense is your responsibility. Please know that submitting a claim to your insurance is not a guarantee of payment and the ultimate financial responsibility is yours.

While NWCCH may be contracted with your insurance, we cannot guarantee we will be in-network to your specific policy or how your health plan will process your claims or cover your visit. It is your responsibility to verify provider networks and understand your benefits and coverage limits for all services you receive. It is also your responsibility to provide the most current and updated information regarding insurance coverage and patient contact information.

Advanced Beneficiary Notice (ABN) and Waiver of Liability: If you have Medicare, you might need to sign an Advanced Beneficiary Notice (ABN) if it is likely Medicare won't cover the procedure, treatment, or service you are receiving. By signing the ABN, you agree to be responsible for payment if Medicare denies payment. For patients with non-contracted insurance or if we anticipate frequent denials from a contracted plan for a specific service, we may ask for a Waiver of Liability.

Fees From Non-Colorectal Health NW Providers and Locations: Our fees cover only services we provide. Occasionally, other provider and facilities not associated with NWCCH may also be involved in your care, such as labs, radiology, pathology, anesthesiologists, hospitals, and surgery centers. These additional providers will bill you separately for their services. If you have a question or concern about a bill you receive from one of these non-NWCCH providers or facilities, you must contact them directly. Unfortunately, we are unable to address issues related to their pricing or how your insurance processed their claim.

Patient Cost Share: You are responsible for all copays, coinsurance, deductibles and all other procedures or treatments not covered by your insurance. Copays are due at the time of service; balances are due 30 days from receipt of your statement. We accept cash, check, and most major credit cards.

Payment Plans: Payment plans may be available if you are unable to make a payment in full. You can request a payment plan through our patient portal or by contacting our office. All payment plans are subject to full account review and require satisfactory payment history. Please note that payment plans do not include any pending or future balances. You must call our office to add any additional balances to a payment plan after you have received your bill. Payment plan terms are subject to change if additional balances are added.

Self-Pay and Patient Estimates: Uninsured and self-pay patients will pay \$187.00 at the time of service for office visits. Please note that your balance may be more than the above stated amount and the final amount owed will be determined based on actual services rendered during your visit or procedure. We offer a 20% cash pay discount off our standard fee schedule for uninsured or self-pay patients.

You can request a cost estimate for our services by contacting our office. Estimates are based on information known to us at the time your appointment is scheduled and do not include additional services that may be ordered or provided during your visit. We are unable to include estimates from non-NWCCH providers or facilities. Please contact them directly to receive cost estimates for their services.

Returned Check Fee: A nonsufficient fee (NSF) of \$35 will be charged for any checks returned due to stop payment or insufficient funds.

Missed Appointments and Late Cancellations: If you are unable to keep your appointment, please cancel at least 48 hours prior to your appointment for office visits. Appointments that are canceled with less than 48 hours' notice are subject to a missed appointment/late cancellation fee of \$75.

Surgeries and procedures, including colonoscopies, require a 14-day notice for cancellations. Appointments canceled with less than 14 days' notice are subject to a \$150 missed procedure/late cancellation fee.

If you arrive more than 5 minutes late to your appointment, you may be asked to reschedule.

If you have 3 or more missed appointments or late cancellations, you may be dismissed from Colorectal Health NW.

Past Due and Collection Accounts: Payment is due within 30 days of receiving your statement. Accounts with balances that remain unpaid for over 90 days from the initial statement or the last payment if on a payment plan may be forwarded to an external collection agency. Once the account is with the collection agency, NWCCH cannot address the outstanding balance, and you'll need to communicate directly with the collection agency to resolve it.

If you are on a payment plan, it is your responsibility to ensure monthly payments are received in our office by the agreed upon due date. If payment is not received by the agreed upon due date, your payment plan will be canceled and subject to further collection efforts. We reserve the right to restrict future payment plans due to non-payment.

ANOSCOPY BILLING INFORMATION

Anoscopy or Proctoscopy is often included in a comprehensive proctologic exam used to identify anorectal problems by allowing the physician to see inside the anal canal and/or rectum. If the doctor conducts an internal examination in the office, it's likely that one of these procedure codes will be billed. *

Possible CPT (Procedure) Codes: *Anoscopy- 46600* *Proctoscopy 45300*

These codes are often considered "procedures or surgeries" by insurance companies; therefore, your insurance carrier may apply the charges to your deductible and co-insurance. This form is to notify you that you may have out of pocket costs associated with this exam that will be billed to you after insurance is billed.

We encourage you to contact your insurance carrier to verify your benefits for this exam if you have questions as to what your out-of-pocket costs will be.

***If you are completing this form before scheduling your colonoscopy and wondering about these codes, they do not apply to the colonoscopy procedure.**

By my signature below, I hereby authorize assignment of financial benefits directly to Colorectal Health Northwest, 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 signing below, I certify that I have read and understand the Colorectal Health NW Patient Financial Policies and accept financial responsibility for payment of any fees associated with my care.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship to Patient

TO THE Patient: You have the right to be informed about your condition and the surgical, medical, or diagnostic procedures suggested for treatment. This includes understanding the risks involved so you can decide whether or not to proceed with any recommended treatment.

Currently, no specific treatment plan has been proposed for you. This consent form is just to ask for your permission to conduct the necessary evaluation to identify the best treatment or procedure for any conditions we find.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and/or other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Oregon law (ORS 441.098) requires us to inform you that:

- You have a choice of where to go when you are referred for a diagnostic test, health care treatment or service.
- When a referral is made, you have the right to talk about your options of where you may go, and the right to choose where you would like to have a test, treatment or service done.
- Your referral will not be denied, limited or withdrawn if you choose another

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship to Patient