Gastroenterology Associates of Western Michigan PLC
2093 Health Dr., Suite 201
Wyoming, MI 49519
(616) 452-7099
(616) 452-4142 Fax

Allan Coates, D.O.
David Tabor, D.O.

Patient Name:_____ **Date of Birth**:_____

Statement of Patient Financial Responsibility

Gastroenterology Associates appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in, implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. The remaining balance will be billed to you and due 30 days from date billed. **All balances not paid within 30 days will be assessed a finance charge of 1.35% on the unpaid balance.**

If you are unable to pay the entire amount within 30 days of receipt, we ask that you contact our office to arrange a monthly payment plan. Failure of payment will result in collection agency action.

Many insurance companies have additional stipulations that may affect your coverage. It is the patient's responsibility to know your coverage and benefits. You are responsible for any amounts not covered by your insurance, including deductible, co-pays and co-insurance.

Co-Pay Policy

Some health insurance carriers require the patient pay a Co-pay for services rendered. **All co-pays are to be paid at time of service.**

Cancellation/No Show Policy

We understand there may be times when you miss your appointment due to emergencies or obligations to work or family. Should you need to reschedule an office visit we ask you give us a minimum of 24 hours notice. To reschedule a procedure we must have a minimum of 72 hours for a colonoscopy and 48 hours for all other procedures. Cancelling with less than the minimum hours or failure to show for an office visit or procedure will result in a fee of $25.00 for office visits and $150.00 for all procedures. All No Shows will require a new referral from your Primary Care Provider (PCP).
After 3 No Shows your PCP will be notified that you are discharged from Gastroenterology Associates of Western Michigan, PLC and must be referred to a different gastroenterologist office for care.

Consent for Treatment and Authorization to Release Information

I hereby authorize Gastroenterology of Western Michigan, through its appropriate personnel, to perform or have performed upon me appropriate assessment and treatment procedures.
I further authorize Gastroenterology Associates of Western Michigan, to release to appropriate agencies, any information acquired in the course of my examination and treatment.

HIPAA Acknowledgement of Receipt

I acknowledge that I have been offered a copy of the Notice of Privacy Practices as a patient under the HIPAA act from *Gastroenterology Associates of Western Michigan, P.L.C.* I further acknowledge that I have had an opportunity to ask questions and received answers to my satisfaction about this policy. **Notice of Privacy Practices Policy is also available at http://www.gastroassocwm.com/forms/PrivacyNotice**

Please list the names of anyone who you give permission to Gastroenterology Associates of Western Michigan, P.L.C. to release any medical information (e.g. Wife): _____

**New Privacy Information: The Health Information Exchange is a "limited view" of your electronic patient chart that may be accessed by different health care facilities for continuing care. If you would not like this information shared, you may "opt-out," that is, you may request your information not to be shared. You may request an instruction sheet from our registration staff to explain the process to "opt-out."

I have carefully read the above policies regarding my financial responsibility to Gastroenterology Associates of Western Michigan. I understand the cancellation policy as noted above. I acknowledge that I have been offered a copy of the Notice of Privacy Practices as a patient under the HIPAA act. I acknowledge my consent for treatment and authorize the release of my medical information to appropriate agencies.

Signature_____ Date_____