GASTROENTEROLOGY ASSOCIATES OF WESTERN MICHIGAN PLC

2093 Health Drive SW, Suite 201
Wyoming, MI 49519
P: 616-452-7099
F: 616-452-4142
https://gastroassocwm.com

Allan Coates, DO
Katherine Baker, FNP
Julia Valdespina, FNP
Sharyn Coates, Dr. O.T.

Statement of Patient Financial Responsibility

The services you have elected to participate in have a financial responsibility on your part which 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 is due 30 days from the 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 your responsibility to know your coverage benefits. You are responsible for any amounts not covered by your insurance, including deductible, co-pays, and co-insurance. **If your insurance requires a prior-authorization, please call (616)452-7099 Option 5. You will be responsible for any denied claims.**

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 to give us a minimum of 24 hours' notice and procedures a minimum of 72 hours' notice. Cancelling with less than the minimum hours' notice above may result in a fee of $25.00 for office visits and $150.00 for procedures. If you arrive ten minutes past your scheduled appointment time, your visit will be cancelled and rescheduled. If you no-show to a procedure, you will not be rescheduled. We require a confirmation for all appointments. By singing below, you consent to Gastroenterology Associates of Western Michigan, PLC reaching out to the number listed in your chart via phone or text. We will call from 616-452-7099 and the text will come from 323-431-9301. Please click the link to view your secure message. You may opt out at any time.

If you do not show up to a new patient appointment or have 3 no-shows, your primary doctor will be notified that you have been discharged from our practice.

I have carefully read the policies regarding my financial responsibility to Gastroenterology Associates of Western Michigan. I understand the cancellation policy of Gastroenterology Associates of Western Michigan. My signature below indicates that I have read, understood, and agree to the policies and procedures of Gastroenterology Associates of Western Michigan.

Signature _____ Date: _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Gastroenterology Associates 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.

Signature _____ Date: _____

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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, PLC.* 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. This form also gives permission to send records to any health care provider listed in your chart.**

Reproductive Health Care: We may not use or disclose protected health information to conduct any investigation related to the mere act of someone seeking, obtaining, providing, or facilitating reproductive health care, to impose any liability regarding the same, or to identify any person for any such purpose. An authorization is not required if the use or disclosure is made for health oversight activities, law enforcement purposes, or pursuant to a judicial or administrative proceeding unrelated to reproductive healthcare, and a valid attestation is provided to us from the person requesting the use or disclosure for such a purpose.

I give Gastroenterology Associates of Western Michigan permission to contact me on the phone number(s) provided in my medical chart, and leave messages with detailed information on the voicemail or messaging system that aligns with the phone number(s) that are documented in my medical chart.

Please list the name(s) of anyone who you give permission to Gastroenterology Associates of Western Michigan to release any medical information (e.g. spouse):

NAME	RELATIONSHIP	CONTACT NUMBER
☐		
☐		
☐		
☐		

Please check box above indicating person whom you would like to list as your emergency contact with our office

*****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 "op-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 acknowledge my consent for treatment and authorize the release of my medical information to appropriate agencies. My signature below indicates that I have read, understood, and agree to the policies and procedures of Gastroenterology Associates of Western Michigan.

Printed Name: _____ DOB: _____

Signature _____ Date: _____