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EXPLANATION OF YOUR BILL

You are scheduled for a procedure at Redding Endoscopy Center. The total cost may be comprised of four provider fees: the Redding Endoscopy Center's fee, the physician's fee, the anesthesia fee, and the pathologist's fee. Each individual provider bills fees separately.

- **Redding Endoscopy Center's fee** covers the cost of providing the technicians, nurses, equipment and supplies involved in the performance of your service. Co-pays, Co-insurance, and Deductibles are due at the time of service. If your insurance company finds you are responsible for an additional balance after processing the claim, you will be billed separately for that amount and payment will be due within 30 days. If you have any questions regarding your bill from Redding Endoscopy Center, please call their **Billing Department** at **(866) 809-1220**.

- The **Physician's Professional Service fee** is for providing the endoscopy procedure, supervising, interpreting and consulting with you and your referring physicians. Your physician will bill you separately for the physician's professional fee. If you have any questions regarding your physician's bill, please call their respective billing offices. **R.D.N.E.C. Billing Department** at **(530) 243-8667**. **Dr. Liu** at **(530) 338-2406**.

- The **Anesthesia fee** covers the cost of providing Propofol anesthesia for your procedure. If you have any questions regarding your bill from anesthesia, please call their **Billing Department** at **(866) 809-1220.**

- The **Pathology fee** is for services if there are biopsies taken during your procedure. You will be billed by Pathology groups reviewing the tissue. Please call them with billing issues. Unless instructed otherwise, your specimen will be sent to the below laboratories. If a different laboratory is preferred, please bring the laboratory information with you.

GI Pathology – 1-888-274-7956 **Shasta Pathology – (530) 255-1000**

Interpreting your insurance explanation of benefits (EOB):

- **Total Charges**: This is the total amount each provider will bill to insurance.
- **Allowed Amount**: This is the total amount expected to be paid by insurance and/or patient combined. (It is also called the negotiated amount or contracted amount).
- **Payable Amount**: This is the amount that the primary insurance will pay.
- **Patient Responsibility**: This is the difference between the allowed amount and the payable amount. This represents any deductibles and co-payments or co-insurance. If you have a secondary insurance they may pay for all or part of the "patient responsibility", depending on your contract.

I have read and understand the above information.

FINANCIAL AGREEMENT

All Co-Insurance and deductible balances for Redding Endoscopy Center (REC) will be collected at the time of service. If there are any additional amounts due, you will receive a bill from Redding Endoscopy Center. You will also be receiving a bill from the Physician for professional fees and if you have a biopsy during your procedure you will receive a bill from the pathology laboratory. Anesthesia services will be billed separately. In the event that your insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physician which render services to me are authorized to submit a claim for payment to my insurance carrier. The Center and/or physician's office is not obligated to do so unless under contract with the insurer or bound by regulation of a State or federal agency to process such a claim. We will expect payment of co-pays and co-insurance at the time of service. Redding Endoscopy Center is a Medicare provider and accepts Medicare assignment. If you have a second insurance, REC will bill them as a courtesy. All co-insurance balances and deductibles are your responsibility and due at time of service. We will bill your first and any subsequent insurance as a courtesy. It is, however, your contract with the insurance company and the final payment is always your responsibility. If your insurance requires a PRIOR AUTHORIZATION for procedure it is YOUR responsibility to contact the performing physician's office to obtain an authorization prior to your appointment. If you do not have an authorization at the time of appointment and we are unable to obtain one, your appointment will be rescheduled. If we provide services without prior authorization, at your request, YOU ARE RESPONSIBLE FOR THE ENTIRE FEE (100%). PAYMENT IS DUE AT THE TIME OF SERVICE. Redding Endoscopy Center will not bill your insurance in this situation. The Center is not a Medi-Cal provider; however your current Medi-Cal Plan information is required at the time. The Center is a Partnership Health Plan provider; please provide your current Partnership HP information. All share costs are your responsibility and due at time of service. Payment for services rendered is due at the time of service. Payment in full is required for all self-pay patients at the time of service for all visits. If you need to make financial arrangements, please make them prior to your visit.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Redding Endoscopy Center, my admitting physician, or other physicians who render services to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of Redding Endoscopy Center, my admitting physicians or other physicians who render services to charge not paid for within a reasonable period of time by insurance or third party payer. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all court costs and reasonable attorney fees. I hereby authorize Redding Endoscopy Center to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize Redding Endoscopy Center, my admitting physician, or other physicians who render services to release all or part of my medical records where required or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care. This is referred to in the notice of privacy practices and in the patient rights.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my procedure that the physicians who perform procedures/services at Redding Endoscopy Center may have ownership interest in Redding Endoscopy Center. The physician has given me the option to be treated at another facility, which I have declined. I wish to have my procedure(s) performed at Redding Endoscopy Center.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Redding Endoscopy Center is correct.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to the date of the procedure. I have also received information regarding Redding Endoscopy Center policies pertaining to ADVANCE DIRECTIVES prior to the date of the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

I have a properly executed Advance Directive that is approved by the State of California: **YES**_____ **NO**_____

If yes, I am providing the center a copy of such today and ask the center to follow my wishes as outlined on this document should I no longer be able to make decisions for myself: **YES**_____ **NO**_____

I would like information on Advance Directives. YES_____ N/A_____ Declines_____

The undersigned certifies that he/she has read and understands the forgoing and full accepts all terms specified above.