East Side Endoscopy, LLC

Disclosure of East Side Endoscopy's Financial Policy and Notice of Patient Responsibility

East Side Endoscopy is a state of the art ambulatory surgical center specializing in providing gastrointestinal endoscopy services. The fees charged for our services are referred to as "facility fees" and is intended to cover the cost of operating the facility, the equipment used during the procedure, the nursing and technical staff, and the cost of medical and other supplies required to ensure the highest quality of care and safety during your procedure. You will receive a separate bill from your gastroenterologist for their professional services, as well as the anesthesiologist who assists in your care. Should tissue samples or polyps be removed during your procedure and sent to the laboratory for any pathology services your insurance company will be billed directly. The facility, gastroenterologist, anesthesiologist and laboratory and are all separate legal entities providing separate and distinct services.

East Side Endoscopy and its affiliated service providers participate in most commercial insurance, Medicare and Medicaid and managed care programs.

Payments received from your insurance company will be applied to your account however, insurance coverage varies widely among carriers and many plans have deductibles, co-payments and co-insurance components that are the responsibility of the patient. Some procedures and providers require authorization prior to the procedure. It is the **patient's responsibility** to ensure that all pre-authorizations are obtained prior to the date of service.

When scheduling your appointment our Patient Services Coordinators will verify your eligibility and the insurance coverage with regard to the services you will be receiving at East Side Endoscopy. All co-payments are due at the time of service. Payments can be made by cash, checks and all major credit cards. Patients will be billed for unmet portions of deductibles as well as co-insurance as defined by their policy. Patients are encouraged to contact the patient services representative at their insurance carriers to better understand their coverage limits and potential liability for this procedure and all their healthcare needs.

Patients are required to provide East Side Endoscopy a copy of their primary and secondary insurance information. As a courtesy to our patients, insurance claims will be submitted on the patient's behalf to the insurance company specified during the registration process

All co-payments, co-insurance and deductibles will be billed by Physicians Endoscopy Billing Department as required by the contract between the patient, the insurer and our center. These fees cannot be waived or discounted.

Some insurers require precertification, preauthorization or a written referral. Obtaining precertification, authorizations and referrals is done by you primary care or referring physician. It is **the patient's responsibility** to understand their insurance plan requirements and confirm that the proper authorization is obtained at least three (3) days prior to the date of service. Failure to obtain the necessary precertification, preauthorization or a written referral may result in cancellation of your procedure.

We recognize that there may be times when full payment is not possible. Patients are encouraged to contact our billing office to make arrangement when warranted by financial hardship or other unforeseen circumstances.

Important Insurance Terminology

We encourage our patients to visit their carrier websites or contact the patient services representative (usually available by calling the telephone number listed on their insurance card) to better understand their individual insurance policy, coverage limits and financial responsibility for all their healthcare needs.

To help patients we have provided a list of commonly used insurance terms.

"Provider": This term is used to describe an individual such as a physician, nurse, or an institution such as a facility, hospital, laboratory or pharmacy providing healthcare to a patient.

"Insurance Carrier": This is the company (United HealthCare, GHI) or program (Medicare, Medicaid) which makes payments to providers for specific services rendered to subscribers.

"Policy Holder": This term refers to the individual who is the primary person on the insurance policy.

"Subscriber": this refers to the person covered by an insurance policy. The subscriber can be the primary policy holder or a dependent (spouse, partner, child).

"Managed Care Plan": Managed care plans provide comprehensive healthcare to members through a specific group of contracted providers. Patients having a "managed care plan" are encouraged to stay within the contracted group or may incur direct fees. Types of Managed Care Plans include HMO's, PPO's, EPO's and POS plans.

Allowed Amount: This is the rate agreed upon by the healthcare provider and insurance carrier to be paid for specific service. This is sometimes referred to as a "contracted rate". If you visit an in-network provider this is the total amount they expect to receive for the services provided. Payments from insurance carriers to providers are automatically reduced by the amount of the co-payments, co-insurance and unmet deductibles stipulated in individual policies.

Co-payment: This is a fixed dollar amount that a patient must pay for a specific service (office visit, procedure, prescription). Co-payments are due when a medical service is received. Payments made to providers by the carrier are automatically reduced by the amount of the patient's Co-payment.

Coinsurance: This is an amount generally expressed as a percentage **(%)** of the allowed amount for a specific service which is the patient' responsibility to pay directly to the provider. Payments from insurance carriers made to providers are automatically reduced by the amount of the patient's Coinsurance. Some plans require the deductible amount be paid first before the coinsurance rate is applied to a fee.

Deductible: This is a specific dollar amount the patient must pay BEFORE the insurance carrier will begin to make payment. Some insurance plans have different types of deductibles (in-network and out of network, per hospital or Emergency room visit, etc). Payments made by insurance carriers to providers are automatically reduced by the amount of the patient's remaining/unmet deductible.

Pre-authorization/ Pre-certification: Some medical services require "approval" from the insurance carrier prior to the date of service to insure payment is made to the provider. Generally primary care providers must provide details or a description of the service to be provided and the medical reasons indicating the need for the service (usually in the form of codes "**CPT"** and "**ICD-9**") to carriers in advance of the service being provided. Carriers will then if approved (i.e. covered under your policy) provide a code to the provider which must be provided with claim submitted for the procedure. **Pre-authorizations and Pre-certification** are often specific providers and for limited time frames.

CPT or **Current Procedural Terminology:** is a set of codes maintained by the American Medical Association. The CPT code describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

ICD-9 or International Classification of Diseases: is a set of codes which classifies diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease. Nearly every health condition can be assigned to a unique category and given a code, up to six characters long.

Explanation of Benefit (EOB): is a statement generated by your insurance carrier detailing the services provided and charges submitted by a healthcare provider and the payments and other adjustments applied to the patient's account balance. An EOB will also provide reasons as to coverage allowances and patient responsibility.