MONTANA GASTROENTEROLOGY

P: 406-541-6844 F: 406-541-6843 www.MontanaGI.com
1930 W. Broadway St., Suite A, Missoula, MT 59808

Dear Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for choosing us to participate in your health care. We look forward to providing you with personalized, comprehensive health care focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your health care needs, our physicians, advanced practice providers, medical assistants, and office staff work closely in a team approach to support your care.

Our team of experts specialize in Gastroenterology and Hepatology. Our areas of expertise include the esophagus, stomach, small intestine, colon, liver, gallbladder, and pancreas. We offer a wide variety of services including:

- *Screening or diagnostic colonoscopy*
- *Upper endoscopy*
- *Esophageal manometry*
- *Gallbladder testing*
- *Ambulatory 24-hour ph testing*
- *Capsule endoscopy*
- *EUS (Endoscopic Ultrasound)*
- *ERCP (Pancreatic & Bile duct procedure)*
- *Fibroscan*
- *Pillcam / Capsocam*

Our office is open Monday through Friday, 8:00am - 5:00pm. Our schedulers are available during these hours to accommodate you. After-hours care will be provided by the on-call physician.

We look forward to seeing you at your upcoming office appointment. It is important that you bring the following:

- Your insurance cards
- Co-payments if applicable

YOU ARE REQUIRED TO CONFIRM YOUR APPT 7 DAYS PRIOR BY CALLING OUR OFFICE OR VIA THE AUTOMATED REMINDER SYSTEM. FAILURE TO CONFIRM YOUR APPT WILL RESULT IN YOUR APPT BEING CANCELLED AND GIVEN TO ANOTHER PATIENT. IN ADDITION, WE REQUIRE 7 DAYS TO RESCHEDULE OR CANCEL YOUR APPT. IF YOU NO SHOW YOUR SCHEDULED APPOINTMENT, YOU WILL INCUR A $100.00 NO SHOW FEE.

Thank you for choosing Montana Gastroenterology for your health care needs. To learn more about our facility and physicians please visit our website at www.MontanaGi.com

Sincerely,

Casey Kolendich, MD
Kevin Kolendich, MD
Ed Levine, MD
Eric Stone, MD
Jeff Willis, MD
Scott Cooper, MD
Amelie Tiritilli, MD
Kari DeBoo, NP-C
Lindsey Gardner, PA-C
Lance Griffin, PA-C
Erin Reed, PA-C
Lisa Weinreich, PA-C
Autum Emerson Howell, NP -C
Taylor Higley, PA-C

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PAYMENT POLICY

Thank you for choosing Montana Gastroenterology. We are committed to providing you with quality and affordable health care. Our patients have the right to know and understand our payment policy. The following outlines our Payment Policy and we ask that you read, ask any questions you may have, and sign in the space provided. A copy will be provided to you, upon request.

1. **Insurance** – We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Self-pay patients will receive a discounted rate if paying in full the day the service was rendered.
2. **Co-payments and deductibles** – All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services** – Please be aware that some and perhaps all the services you receive may be noncovered or not considered reasonable or necessary by your insurance carrier. You will be responsible for these services in full at the time of the visit. Again, it is your responsibility to know what your insurance benefits are and what will be covered.
4. **Proof of insurance** – Patients are required to update all demographics and insurance information before seeing a provider. We must obtain a copy of your driver's license and current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission** – Montana Gastroenterology will submit claims to the insurance carrier on file. We will assist you in any way we reasonably can to help get the claim(s) paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility.
6. **Coverage changes** – If your insurance changes, please notify our office immediately. Preference would be before your scheduled appointment, so we are better prepared for your visit. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you.

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7. **Nonpayment** – If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with our Billing office. Please be aware that if a balance remains unpaid, we reserve the right to any of the following:

    a. Account will be turned over to a collection agency.
    b. You will be unable to schedule any future appointments or procedures until balance is paid in full.
    c. You will be dismissed from practice. If dismissed from practice, you will be notified by regular and certified mail that you have 30 days to find alternative medical are. During that 30-day period, the provider on file will only be able to treat you for emergent issues.

8. **Missed appointments** – Montana Gastroenterology's policy is to charge for missed "no show" appointments not cancelled within 24 hours. This charge will be **$100.00** This charge will be your responsibility and billed directly to you. Please help us to avoid this charge and serve you better by keeping your scheduled appointment and or procedure.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary fees for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Should you need to speak to one of our billing representatives, **please call 866-785-9296.**

I have read and understand the payment policy and agree to abide by the outlined guidelines.

_____ _____

Signature of patient or legal responsible party **Date**

Patient label