

LAKESIDE ENDOSCOPY CENTER, LLC

FINANCIAL POLICY

We would like to take the opportunity to welcome you to our facility and to let you know that we are committed to providing you with the best possible care. Thank you in advance for reading this information, it is critical that you understand our Financial Policy. We will gladly discuss your proposed treatment and answer any questions.

We are here to assist you in providing information to your Health Insurance Company. Please keep in mind that not all services are a covered benefit in all plans and that your insurance coverage is an agreement between you and your Health Insurance Company. Payment for services at Lakeside Endoscopy Center, LLC, are ultimately the patient's responsibility.

If you are scheduled for a colonoscopy: Please understand all colonoscopies are not screening/preventative and may be deemed medical based on your medical history. Deductibles, copays, and co-insurance may apply. The Facility submits procedural documentation and charges according to the Medicare and Medicaid Services and American Medical Association guidelines and is not responsible for determining how benefits are paid by your insurance plan. Please make sure your insurance company allows your procedure at our Facility. If you have questions, please call us at (402) 504-3846 for a more detailed explanation.

If you have insurance, we will submit charges to your primary and secondary insurance provided we have a copy of your assignment of benefits as well as a copy of your insurance card(s). Patient deductibles, coinsurance and co-payment amounts are established by your Health Plan and are your responsibility. Patients who fail to provide insurance information are directly responsible for payment of their account at the time of service unless other arrangements have been made.

If your Insurance Plan requires authorization for care or treatment, it is the patient's responsibility to obtain this prior to their visit. Contact your Insurance Carrier if you are not sure. If a precertification is required it will need to cover your facility charge (Lakeside Endoscopy Center), the physician charge, laboratory/pathology, and anesthesia services. If a precertification is not obtained, your insurance company may deny coverage, which could result in patient responsibility.

Prompt payment of your account is expected; however, we realize that situations may arise whereby you may have difficulty meeting your obligation. If such problems arise, we encourage you to contact our office for assistance in the management of your account. We do use outside agencies as a means of collections should your account become delinquent.

If you do not have insurance, acceptable financial arrangements will need to be made prior to the date of service. An account representative will be happy to assist you and can be reached at (402) 397-7057. Please note a deposit will be required at the time of procedure.

You will receive multiple billings. These may include the following:

- **Facility Fee:** Lakeside Endoscopy Center, LLC will bill a charge for the use of the Ambulatory Surgery Center.
- **Physician Fee:** You will receive a bill from the physician's office that provides the service.
- **Laboratory and Pathology Fee:** If you have blood drawn and/or biopsy(s) taken there will be a charge from the laboratory or laboratories that process your blood work and/or biopsy(s).
- **Anesthesia Services Fee:** Monitored Anesthesia Care (MAC) will be provided by a Certified Registered Nurse Anesthetist and be billed by Midwest Gastrointestinal Associates, P.C.

If you have any questions regarding your billing(s) please contact us at (402) 397-7057.

Lakeside Endoscopy Center, LLC accepts checks, cash, Visa, MasterCard, Discover, American Express, and debit cards. Online payments can be made at: www.midwestgi.com/pay-bill-online/.

AUTHORIZATION

I understand that the physician who is rendering services may have an ownership interest in the above referenced facility. The physician or the physician's representative has given me the option to be treated at another facility, which I have declined. I wish to be treated at Lakeside Endoscopy Center, LLC.

I have read and agree to the terms and conditions listed above and I hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to Lakeside Endoscopy Center, LLC. I understand the above stated charges and that I am responsible for my balance in full. I understand I am financially responsible to Lakeside Endoscopy Center, LLC, the physician charge, laboratory/pathology, and anesthesia services charges not covered or denied by my insurance company. A photocopy of this agreement shall be valid as the original. This authorization is to remain in effect until revoked in writing by me or my legal representation.

Signature

Date

At Lakeside Endoscopy Center, LLC, patient care, safety & satisfaction are very important to our entire staff. In order to provide the best care possible, we want to partner with you in maintaining your safety & satisfaction. If at any time you, your legal representative and/or surrogate have questions or concerns regarding any aspect of your care, please contact Lakeside Endoscopy Center for assistance or clarification.

Patient Rights

Every patient has the right to be treated fairly, with respect, consideration, dignity and as an individual. We assure the rights of all patients coming into the Center are respected without regard to race, gender, color, national origin, disability, age, religious or fraternal organization, or any other factor protected by law.

1. Patients are treated with respect, consideration, dignity and provided safe care by competent personnel without discrimination.
2. Patients are informed of patient rights during the admission process.
3. Patients are provided appropriate privacy.
4. Patient disclosures and records are treated confidentially, except when required by law, and patients are given the opportunity to approve or refuse their release.
5. Patients are free from abuse, neglect and exploitation.
6. Patients are given access to the information contained in his/her medical record within a reasonable time period when requested.
7. Patients are informed both of their right to formulate an Advance Directive at the time of admission and the facility’s policy regarding Advanced Directives.
8. Patients are informed in advance about care, treatment and associated risks.
9. Patients are given information necessary to make informed decisions regarding their care and treatment. When it is medically inadvisable to give information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
10. Patients are provided information about treatment alternatives and will be advised of the risks, advantages and disadvantages of each.
11. Patients have the right to refuse care, treatment and services and to be informed of the medical consequences of refusal of care.
12. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
13. Patients have the right to refuse to participate in experimental research
14. Patients have the right to know, in advance, the type and expected cost of treatment.
15. Patients have the right to be informed of the professional rules, laws and ethics that govern the organization and its employees.
16. Patients, families, and /or and legal representatives or surrogates have the right to effective communication in a manner they can understand. The Center will take reasonable steps, free of charge to the patient, to provide access to tools and services to provide effective communication. These include, but are not limited to interpreters, large print paperwork and selected transcribed documents.
17. Patients will receive services without discrimination based upon race, color, religion, gender, national origin, or payer. Health clinics are not required to provide uncompensated or free care and treatment unless otherwise required by law.
18. Patients, families, and /or and legal representatives or surrogates have the right to express grievances and suggestions to the organization without discrimination or reprisal and have those complaints and grievances addressed with in a timely manner.

Advance Directive Policy

Due to the nature of procedures and the generally healthy status of patients seen at the Center it is the conscious decision and policy of the Center **not** to withhold lifesaving actions in the event of life threatening emergencies. In accordance with Nebraska HHS Regulation and Licensure 7-006.04, this will serve as notice to the patient, the patient’s representative, or surrogate of the policy limiting advance directives. In the event a life-threatening emergency occurs (i.e. respiratory or cardiac arrest), the Center will perform emergency procedures as necessary to stabilize the patient and then transfer the patient and the advance directive documentation, if provided, to an acute health care facility where the attending physician, the patient’s representative or surrogate and family can make an informed decision regarding the patient’s well-being.

To comply with state law, during the registration process, you will be asked if you have an advance directive. Please bring a copy if you have one. If you do not have an advance directive and would like further information please call us at (402) 614-2300. Upon request we will mail information regarding advance directives or will have it available to you at registration.

Physician Ownership Notice

The physician who is rendering services may have an ownership interest in Lakeside Endoscopy Center, LLC. During the scheduling process, the physician’s representative will give you the option to be treated at alternate facilities. If you wish to be treated at another facility please notify your physician’s office.

I acknowledge that any pathology specimens obtained during my procedure will be processed and clinically diagnosed by Midwest Gastrointestinal Pathology Department.

Patient / Responsible Party Signature

Date