



Procedure Acknowledgment of Receipt of Notice

I acknowledge that I have received, read, and understood the following notices provided below:

- Acknowledgment of Receipt of Notice of Privacy Practices (HIPAA)
- Consent for Treatment
- Assignment of Benefits and Billing Authorization
- Patient Financial Policy
- SWE Center Policies
- Understanding Your Procedure Fees
- Acknowledgment of Anesthesia Services
- Anesthesia Service Financial Responsibility Agreement
- Insurance Notice: Laboratory and Imaging Services

By signing this form, I acknowledge that I was offered the option to complete an “Authorization to Discuss Medical and Financial Information” form. This form lets me name individuals I authorize, so the practice may share my medical and/or billing information with them.

I understand that I can obtain these notices on SWGA’s website (www.southwestgi.com) and on the patient portal. Please ask the front desk receptionist if you require a paper copy.

If you have questions regarding these notices, please contact our office at 505-999-1600.

Patient Printed Full Name

Date

Patient Signature

Guardian Printed Full Name *(if applicable)*

Guardian Signature

Date

Staff Use Only

I attempted to obtain the patient's signature in acknowledgment of these Notices but was unable to do so, as documented below.

Date: _____ Initials: _____ Reason: _____



Southwest Gastroenterology Associates P.C.

7788 Jefferson St NE Albuquerque, NM 87109

Phone: 505-999-1600 Fax: 505-999-1650

Southwestgi.com

Acknowledgment of Receipt of Notice of Privacy Practices- HIPAA

I acknowledge that I have received, read, and understood the Notice of Privacy Practices. I know I have the right to request a copy of the full HIPAA acknowledgment that provides a complete description of how my health information may be used and disclosed. I also understand that Southwest Gastroenterology Associates reserves the right to change its Notice of Privacy Practices occasionally. I may contact them anytime to obtain a copy of the Notice of Privacy Practices. I know that I may request in writing to restrict how my information is used or disclosed to carry out treatment, payment, or healthcare operations. However, I understand that Southwest Gastroenterology Associates may not be required to comply with my request.

I, _____, have received a copy of this office's HIPAA policy.

Patient Name

Guardian Printed Name (if applicable)

Patient Signature

Guardian Signature

Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgement but was unable to do so, as documented below.

Date:

Initials:

Reason:



Consent For Treatment

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure(s) to be used so that you may make the decision whether to undergo any suggested treatments or procedures after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that:

- 1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and
- 2) you consent to treatment at this office or any other referring office that may be necessary for treatment or testing.

The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

You have the right to discuss the treatment plan with your healthcare provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and/or mid-level provider, Nurse Practitioner or Physician Assistant, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing and invasive or interventional procedures are recommended, I will be informed prior to services rendered.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Personal Representative

Date

Relationship to Patient/Self

Print Employee Name & Job Title
(Internal use only)

Date



ASSIGNMENT OF BENEFITS AND BILLING AUTHORIZATION FORM

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. You agree to fill out and complete all necessary forms that may be required for your particular insurance carrier. In some cases, the exact insurance benefits cannot be determined until the insurance company receives the claim and the claim is paid.

Assignment of Benefits

I hereby assign all medical and mental health benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other mental health/medical plan, to issue payment check(s) directly to Southwest Gastroenterology Associates for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **SWGA** to:

1. Release any information necessary to insurance carriers regarding my therapy and services. I understand that my healthcare provider may be required to release certain information to the insurance company at their request in order to procure necessary authorizations and process claims for payment. This information may include, but is not limited to, types of service, dates of service, times of service, diagnosis, treatment plans, progress of treatment, and, at times, treatment notes and/or summaries. I authorize the release of such information if necessary, understanding the limits of confidentiality regarding the use of my insurance benefits. I also acknowledge receipt of the **SWGA** Notice of Privacy Practices.
2. Request payment of insurance benefits be made directly to Southwest Gastroenterology Associates for services performed.
3. If necessary, file a formal written complaint, if permitted by law, on my behalf to the state Insurance Commissioner or other appropriate state agency if payment for services is not timely received. I have requested treatment services from SWGA on behalf of myself and/or my dependents. I understand that by making this request, I will become fully financially responsible for all charges incurred during the authorized treatment. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.
4. **Prior Authorization:** SWGA will obtain prior Authorization for patients having procedure at our facility SWE. Prior authorization may be required for specific lab tests or imaging, due to the high patient volume it will be the responsibility of the patient to notify their insurance.

Patient name: _____

DOB: _____

Signature of Patient/Guardian: _____

Date: _____



Patient Financial Policy

1. **OUR GOAL:** To provide and maintain a good physician-patient relationship, letting you know in advance of our financial policies allows for good flow of communication.
2. **CREDIT CARD ON FILE:** We offer patients the convenience of placing a credit, debit, or HSA card on file. Credit, debit and HSA cards are encrypted and stored securely by Elavon, a U.S. Bank. No card numbers are stored in our office or on our electronic medical record system. You may be asked to leave a card on file for co-payments, co-insurance, deductibles, and no-show fees/cancellations. If your card expires or becomes uncollectable when it is on file, we will request an alternative form of payment.
3. **INSURANCE:** Insurance is a contract between the patient and the insurance company. It is the patient's responsibility to provide the insurance information. If you do not have insurance, payment is collected at the time of service. The patient must present a current insurance card and valid ID/ Driver's License at the time of the visit.
4. **CO-PAYMENT:** Co-payment is collected at the time of service. We accept cash, check, credit, debit or HAS cards. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges by your insurance company.
5. **CO-INSURANCE:** Co-insurance is the percentage of covered health costs you are responsible for paying after you have met your deductible. The co-insurance percentage can be found on your insurance card. All co-insurance percentage amounts vary and are due at the time of service.
6. **DEDUCTIBLES:** The deductible is the amount you pay for covered healthcare services before your insurance plan starts to pay. All deductible amounts vary and are due at the time of service. If you have a credit, debit, or HSA card on file, it will be utilized to settle any additional balances not credited to your account at the time of service.
7. **NO-SHOW FEES:** Any patient who fails to keep an appointment will be charged \$50.00 for office visits and \$200.00 for scheduled procedure appointments. The fee must be paid prior to scheduling/rescheduling any appointments.
8. **OFFICE CANCELLATIONS:** Office cancellations must be made 2 business days prior to your scheduled appointment. Any cancellation made with less than 2 business days notice will result in a non-refundable charge of \$50.00. For Monday

appointments, cancellations must be made by noon on the preceding Friday. This fee will be collected prior to scheduling/rescheduling any appointments.

9. **PROCEDURE CANCELLATIONS:** Cancellation of procedure appointments must be made 4 business days prior to the scheduled procedure appointment. Any cancellation made with less than 4 business days notice will result in a non-refundable charge of \$200. For Monday appointments, cancellations must be made by noon on the preceding Friday. This fee will be collected prior to rescheduling the appointment.

10. **BALANCES:** If your account has an outstanding balance, you will be asked to bring the account up to date. Credits on your account will be refunded to the card on file, if listed.

11. **COLLECTIONS:** We use Transworld collections agency. In the event an account is placed in collection status, the account would need to be paid in full prior to scheduling any appointment.

We will verify your benefits prior to appointments to ensure that we collect the appropriate amount for your co-payment or deductible. Our billing department reviews all claims to ensure the claim has been processed and properly paid. Patients typically receive their explanation of benefits (EOB) before the practice. You must contact your insurance carrier immediately if you disagree with your (EOB).

I have read and understand this patient financial policy and agree to comply and accept responsibility for any required payment. I acknowledge and assume responsibility for all charges incurred and for payment of services at the time rendered.

Patient Name (please print): _____

Date: _____

Patient Signature: _____

DOB: _____

SWE Center Policies

Thank you for choosing Southwest Endoscopy for your medical care. We are sharing these policies so you are aware of and understand our current center policies. Please refer to our website for policy updates.

CENTER POLICIES EFFECTIVE: November 1, 2024

- Hours of Operation:** Our center is open Monday – Thursday, 6:00am – 4:30pm and Fridays, 6:00am-3:00pm. Doors may be locked earlier than listed times.
- Insurance:** It is the responsibility of each patient to verify with their insurance whether Southwest Endoscopy and the provider you see are contracted in-network providers. We will make every effort to assist you, but Southwest Endoscopy will not be held accountable for understanding your insurance plan.
- Card on File:** Our center requires a credit or debit card to be on file. Credit cards are encrypted and stored securely by Elavon, which is a part of USBank. There are no credit card numbers stored in our office or our electronic medical record system.
- Appointments:** We see patients by appointment only. Please arrive **60** minutes prior to your scheduled appointment to allow adequate time to prepare you for your visit. If you have any changes to your demographic information (such as a change of address or insurance), please notify our staff when scheduling your appointment or upon check-in. You must arrange for a responsible adult to drive you home after the procedure. You will **not be allowed** to drive yourself, and may not take Uber, Lyft, taxi, or public transportation unless accompanied by an adult companion.
- After-Hours & Holidays:** Our answering service is available after hours, weekends, and holidays for urgent concerns that cannot wait until the next business day.
- Emergencies:** If you have a life-threatening emergency, call **911** immediately.
- Cancellations/No-Shows:** Appointments are in high demand. If you cannot keep an appointment, we require your cancellation notice no later than **4 business days** prior to your appointment. *If notice is not received 4 business days prior to your scheduled appointment, you will be billed a **\$200.00** non-cancellation fee.*

Patient Dismissal:

While we make every effort to work with our patients, sometimes we feel that we are unable to maintain a viable provider-patient relationship, and it is best for all involved to have you obtain your medical care elsewhere. If you are dismissed from the practice, you will have 30 days for emergency treatment only. You will be required to seek the services of another provider in another office. Failure to keep appointments, non-compliance, driving post procedure, non-payment, failure to make payment arrangements, seeing another GI Provider, making demands, using profanity, rude behavior, and/or threatening language are common reasons patients may be dismissed from Southwest Endoscopy.

**Insurance Notice:
Laboratory and Imaging
Services**

We would like to inform you that some laboratory tests and imaging services recommended as part of your care may not be covered by your insurance plan. Coverage varies depending on your specific benefits and insurance provider. We strongly recommend that you contact your insurance company prior to your appointment or procedure to confirm whether these services are covered and to understand any potential out-of-pocket costs. If you have any questions or would like assistance in obtaining procedure codes or service descriptions to provide to your insurer, please don't hesitate to reach out to our office.

Test Results:

We do our best to ensure that your results are posted on the patient portal. This may occur prior to review by your provider. Once reviewed, your provider will comment on your results including any further action required by you. If you are unable to locate your test results, please contact our office.

Prescriptions & Refills:

The best time to obtain a prescription is at your appointment.

Narcotics:

We do not prescribe narcotics.

**Mail Order
Prescriptions:**

Please ensure we have the correct pharmacy for mail order prescriptions.

By signing this form, I _____ acknowledge that I have reviewed, understand, and agree to the policies stated above.

Patient Signature

Date



UNDERSTANDING YOUR PROCEDURE FEES

Please review the information below to understand the fees associated with your procedure. By signing this form, you acknowledge that you have been informed of how billing works and what charges you may expect.

1. **“Professional Fee”** This fee is for the physician performing your procedure. The professional fee for the physician will be billed through Southwest Gastroenterology Associates.
2. **“Facility Fee”** This fee is for the use of the endoscopy equipment, medications and nursing staff at the facility, and is billed through Southwest Endoscopy.
3. **“Pathology/ Laboratory Fee”** This fee covers the examination and diagnostic evaluation of any tissue removed during your procedure. Billing may come from Southwest Gastroenterology or an affiliated laboratory provider based on where the specimen is processed.
4. **“Anesthesia Fee”** This fee is for monitoring the patient during the procedure and administering local anesthesia together with sedation and analgesia. MAC anesthesia is safer and allows patients to recover sooner, and is billed through Southwest Gastroenterology Associates.

A. Please be advised: anesthesia services may be rendered by an outside entity with whom Southwest Endoscopy is contracted but not directly employed.

The above charges are generally “covered” by insurance; however, you may have a shared cost for each one of the above fees including a deductible. If your insurance does not cover the cost of your Monitored Anesthesia Care, Southwest Gastroenterology will accept a flat fee rate of \$175.00 for the anesthesia service fee only. We will gladly assist you with financial arrangements at your request. We use Transworld Collections Agency in the event an account is placed in collection status.

If a procedure is failed or discontinued for any reason and a secondary procedure is completed, both the initial procedure and the secondary procedure will be billed separately to the insurance provider. The insurance company will be charged for both procedures as distinct services, and the appropriate coding and billing will be applied for each procedure, in accordance with insurance policies and applicable healthcare regulations.

I have read and understand the Procedure Fees Policy and agree to comply with and accept responsibility for any payments due.

Patient Name: _____

DOB: _____

Patient Signature: _____

Date: _____



Acknowledgment of Anesthesia Services

I understand and acknowledge the following:

- Anesthesia Provider:** Anesthesia Associates of New Mexico, P.C. (“AANM”) provides monitored anesthesia care (“MAC”) during procedures performed at Southwest Endoscopy. MAC is a form of anesthesia care in which a licensed anesthesia provider (i.e., a physician anesthesiologist or a certified registered nurse anesthetist) provides sedation and pain relief while allowing patients to maintain consciousness.
- Separate Entity and Contracting:** Southwest Endoscopy has entered into a contractual relationship with AANM, a New Mexico professional corporation, to provide anesthesia services to patients undergoing procedures at Southwest Endoscopy. While these services are coordinated as part of your overall care, AANM maintains its own records, billing practices, and policies. AANM is an independent entity and is not owned, operated, or controlled by Southwest Endoscopy or Southwest Gastroenterology.
- Anesthesia Services:** The licensed anesthesia providers employed by or contracted with AANM will be responsible for administering and managing my anesthesia care before, during, and after my procedure at Southwest Endoscopy. I will receive MAC administered by a licensed anesthesia provider employed by or contracted with AANM unless I decline sedation. If I decline sedation, my procedure may be rescheduled based on my provider’s recommendations.
- Separate Billing:** Charges for anesthesia services may be covered by insurance; however, patients may be responsible for a deductible, co-pay, or co-insurance depending on their individual insurance plan..
- Insurance Coverage:** The charges for the anesthesia services I receive at Southwest Endoscopy may be covered by insurance. However, depending on my insurance plan, I may be responsible for a deductible or have a co-pay or co-insurance obligation.

AANM Contact Information

For questions about anesthesia services, billing, or records, please contact:

Anesthesia Associates of New Mexico, P.C.
Patient Account Department: 1-800-222-1442 (BILLING)
11024 Montgomery Blvd NE #304
Albuquerque, New Mexico 87111-3962

By signing this form, I acknowledge that I have read, understand, and agree to all the information and statements provided above.

Patient’s Full Name (Printed)

Patient’s Date of Birth

Patient’s Signature

Today’s Date



Anesthesia Service Financial Responsibility Agreement

Patient Name: _____

Date of Birth: _____

Procedure Date: _____

Purpose

Certain insurance plans may determine that anesthesia services for your procedure are **not medically necessary**. In such cases, your insurance company may deny payment for anesthesia services.

Patient Financial Responsibility

If anesthesia services are denied by your insurance company as **not medically necessary**, you (the patient or guarantor) agree to be financially responsible for a **flat rate fee of \$175.00** for those anesthesia services.

This fee will be billed directly to you, and payment will be due within 30 days of receiving the bill.

Acknowledgment and Agreement

By signing below, you acknowledge that:

- You have been informed that your insurance company may deny anesthesia coverage for this procedure.
- You understand and agree that you will be responsible for a \$175.00 flat fee if coverage is denied for lack of medical necessity.
- You have had the opportunity to ask questions regarding this policy.

Patient (or Legal Guardian) Signature: _____

Date: _____

Printed Name: _____

Witness/Staff Signature: _____

Date: _____



Southwest Gastroenterology Associates P.C.

7788 Jefferson St NE Albuquerque, NM 87109

Phone: 505-999-1600 Fax: 505-999-1650

Southwestgi.com

Insurance Notice: Laboratory and Imaging Services

Health insurance generally covers blood work and some imaging, though the extent of coverage can depend on several factors, including the type of test, the reason for the test, specifics of your insurance plan, and whether the lab is in-network or out-of-network.

Key considerations include:

- **Preventive vs. Diagnostic:** Under the Affordable Care Act (ACA), preventive services, which may encompass certain types of blood work, are often fully covered without a copay or coinsurance, regardless of deductible status. This may include tests for cholesterol levels, diabetes, certain cancers, HIV, and others based on age and risk factors. Diagnostic blood work, performed to diagnose symptoms or monitor conditions, may not be considered preventive and could incur out-of-pocket costs.
- **In-Network vs. Out-of-Network:** Insurance plans typically have networks of providers offering lower rates. Using an in-network lab usually results in lower out-of-pocket expenses. Some plans offer partial coverage for out-of-network labs with higher costs, while others, such as HMOs and EPOs, generally cover out-of-network services only in emergencies.
- **Deductibles, Copayments, and Coinsurance:** Your plan may require you to pay a deductible before coverage begins. Subsequently, copayments (fixed amounts) or coinsurance (a percentage of cost) might apply for each service.
- **Prior Authorization:** Certain lab or imaging tests may need prior authorization from your insurance company, meaning you **MUST** contact your insurance company to see if this may require a PA-if so, advise our office to obtain approval before performing the test. Without this approval, the service may not be covered.

We do our best to ensure that you're testing and lab services are covered by your insurance. However, due to the wide variety of insurance plans and the high volume of patients we see, it can be challenging to determine the specific coverage details for each individual plan. We recommend checking directly with your insurance provider to confirm your coverage for any specific tests or services. If you need assistance, please contact our office directly 505-999-1600.

Patient Signature

Date