



MIDWEST THERAPEUTIC ENDOSCOPY CONSULTANTS

2821 N. Ballas Rd., Suite 110
St. Louis, MO 63131
Phone: 314-628-9000
Fax: 314-994-1997

Date of Visit: \_\_\_\_\_

Patient Information

Dr. Mr. Mrs. Ms. Jr. Sr.

Patient Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Status: Married Single Divorced Widowed Other

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: Male Female Social Security Number: \_\_\_\_\_

Race: American Indian/Alaska Native Asian Native Hawaiian or other Pacific Island African American Caucasian
Ethnicity Hispanic or Latino Not Hispanic or Latino

Phone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Status: Employed Unemployed Retired Student Highest Level of Education: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance and Responsibility Party Information

Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

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ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

HIPAA Communication Preference

In order for our office to better communicate with you, please indicate your preference below:

What is your primary phone contact? Cell Home Work May we send you text messages? Yes No

May we leave you a voice mail? Yes No May we communicate with you by email? Yes No

May we communicate with anyone on your behalf? Yes No

Contact Name: \_\_\_\_\_ Phone # \_\_\_\_\_

I agree that the information supplied on this form is accurate to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**IMPORTANT INFORMATION ABOUT YOUR PHYSICIAN'S CHARGES**

Physician charges are for services rendered by the physician for medical care. Prompt payment of these charges is appreciated and helps us to provide medical care for all of our patients at a reasonable cost.

Please remember that insurance is a contract between you and Medicare or your Insurance Company. You are responsible for obtaining referrals when necessary and knowing what hospitals and providers are in your "network". Ultimately it is your responsibility to see that your bill for care rendered by the providers is paid.

All charges noted on your bill from our office reflect fees charged by the physician for services rendered in the office, hospital or surgery center. When you are seen in either the hospital or the surgery center, you may receive additional bills from the hospital or surgery center, which are separate from our statement.

**Cancellation Policy**

The physicians and staff of Midwest Therapeutic Endoscopy Consultants, LLC appreciate each patient. Our staff works diligently to ensure each patient appointment request is satisfied at a time and location most convenient to the patient. When a patient does not show for their appointment, they not only waste the physicians' time, but also deprive other patients of timely care. With this in mind we have found it necessary to institute a no-show policy. Effective 6/1/08 Midwest Therapeutic Endoscopy Consultants, LLC (MTEC) reserves the right to **charge a \$75 fee** to any patient who fails to provide a twenty-four (24) hour notice of an inability to attend an appointment.

**Payment Policy**

You are responsible for paying any charges not covered by your insurance provider including, but not limited to; charges for co-payments, annual deductibles, non-covered services and services rendered without a required referral from your primary care doctor as well as any collection fees incurred. You should also consult with your insurance provider to confirm the charges for which you are responsible. Charges not covered by your insurance must be paid during the office visit unless other arrangements have been made in advance. All charges are due and payable within fifteen (15) days of the first billing statement.

For your convenience we accept cash, checks, MasterCard, Visa and Discover. A \$20 fee plus an amount equal to the actual charge will be added to your account for a dishonored check.

**Insurance Information**

**MEDICARE:** Our practice accepts Medicare assignment. We will file Medicare claims and Medicare will pay us directly. If applicable you are responsible for the twenty percent (20%) co-insurance, annual deductible, and any non-covered charges. Please note that some hospitals and surgery centers are NOT accepting some of the Medicare Advantage (PFFS) plans.

**COMMERCIAL INSURANCE:** We will file claims for your convenience. You are responsible for any co-payments, annual deductible amounts and charges for non-covered services. Co-payments must be made at the time of your visit. If a referral from your primary care doctor is required, you are responsible for obtaining and providing it to us at or before the time of your visit. If you fail to obtain a referral, you will be responsible for all charges. Most insurance Companies will send payment directly to us. In the event our payment is mailed to you, you are responsible for forwarding the payment to us along with any balance due on your account.

**MEDICAID:** Your Medicaid card must be presented at the time of service. You are responsible for paying any Medicaid co-pays or spend down amounts. If you have a Medicaid HMO product our office is NOT in network and will require a pre-approval from the HMO as well as a referral from your primary care physician before your appointment or payment in full will be required at the time of your office visit.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

If you have any questions regarding your bill, please ask to speak with our Billing Department. We will work with you on a payment schedule if necessary on any outstanding charges. Thank you for your cooperation.

