Financial Policy: Ambulatory Surgical Center

Billing Questions:
(336) 714-1262

1. If we anticipate that you will incur out-of-pocket costs for your procedure, you will receive an estimate via MyChart or mail approximately one week prior to the appointment. Payment is due at the time of service, which may include copays, deductibles, coinsurance, and past due balances. We collect these balances as part of our contract with your insurance company.
2. We will submit insurance claims on your behalf. Information needed to process your claim with your insurance company should be received and verified prior to your appointment. Coverage for your procedure is determined by your contract with your insurance company. We recommend that you contact your insurance company before receiving services.
3. In some situations, if a patient has insurance with which we do not participate, we may be able to file a claim as a courtesy. However, the balance will remain the responsibility of the patient.
4. Patients that do not have insurance are expected to pay for services at the time of service unless prior arrangements have been made with us. The amount due will be indicated on the estimate letter sent to the patient prior to the procedure.
5. We accept payment by cash, checks, money orders, Visa, MasterCard and Discover. You will receive a statement for any remaining balance, which is due upon receipt. Our office will charge a $25 fee for all returned checks. A detailed statement is available upon request. For questions, charge disputes or for special payment arrangements, contact our billing office.
6. Patients will receive monthly statements for amounts that are the responsibility of the patient. If after several attempts have been made to collect an unpaid balance and there has been no response in the form of a payment on the balance due, any unpaid balances may be referred to an outside collection agency.
7. Patient refunds are issued within 45 days after an overpayment is identified, usually after insurance pays. Overpayments will be refunded by check to the guarantor's address that is on file as of the last visit.
8. Your insurance may provide different coverage depending on the category of your procedure. Many insurance companies follow the guidelines for colonoscopy as defined by The U.S. Preventive Services Task Force (USPSTF).
    a. A procedure is considered "**screening**" if the patient has no symptoms and no personal history of colon polyps.
    b. A procedure is considered "**diagnostic**" if the patient has signs, symptoms, and/or polyp removal.
    c. A procedure is considered "**surveillance**" if the patient has a personal history of colon polyps, colon cancer, or gastrointestinal disease and is being screened at intervals less than every 10 years.
    d. A patient is considered **"average risk"** if he/she is without symptoms and has no personal history of colon polyps or colon cancer, no family history of colon cancer, and is being screened at 10-year intervals.
    e. A patient is considered **"high risk"** if he/she has a personal history of colon polyps or colon cancer or a family history of colon cancer and is being screened at intervals less than every 10 years.
9. You may incur charges for the following services related to your procedure:
    a. **Physician Fee** ⇨ The fee for the physician performing your procedure.
    b. **Facility Fee** ⇨ The fee for the use of the facility, equipment, supplies, medications necessary for your procedure.
    c. **Pathology Fee** ⇨ If a biopsy is taken or a polyp is removed, you may incur a fee from GAP for the professional part or Quest Diagnostics for the technical part of your pathology test. You may call GAP at (336) 714-1262, or Quest Diagnostics at (866) 697-8378 with questions about your pathology bill.
    d. **Anesthesia Fee** ⇨ Anesthesia services at GAP are provided by Anesthesia Care Services under a fee for service contract. For questions concerning your anesthesia charges or bill, call Anesthesia Care Services at (888) 447-7220.
10. The primary CPT procedure code(s) used for filing a claim with your insurance company are Colonoscopy (45378) and Endoscopy (43235). Depending on procedure findings, your CPT code is subject to change.
11. If our endoscopy centers are considered non-participating or out of network with your insurance company, our physicians can also perform procedures at hospital-based facilities. This option may result in you having more out of pocket expense. We encourage you to contact your insurance company to verify participation and reimbursement status specific to your plan.
12. When your procedure is performed in one of our endoscopy centers, the place of service will be filed with your insurance as: **Location 24 "Ambulatory Surgical Center/Outpatient"**
13. **Information for all Medicare patients:** Colorectal cancer screening tests are considered "preventative services" paid 100% by Medicare. However, if a polyp is removed during the course of the procedure, Medicare may interpret the test to be diagnostic, and may require that coinsurance or copays to be billed to the patient.

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