



Columbia Outpatient Sedation

571-535-2502

Cascades Endoscopy Center, LLC | Olney Endoscopy Center, LLC
Annapolis Endoscopy Center, LLC | Riverdale Endoscopy Center, LLC
Timonium Endoscopy Center, LLC | Rockville Endoscopy Center, LLC

Your anesthesia care will be provided by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA). Anesthesia is commonly a covered component of your surgery. Your anesthesia claim will be filed directly to your primary insurance carrier and then to your secondary insurance carrier (if applicable) after the primary payment. We have accepted assignment of benefits and your insurance carrier should send the payment directly to our remittance address.

If your insurance carrier sends the payment directly to you, please endorse the back of the check and list **“Pay to the order of (Columbia Outpatient Sedation),”** above your signature **OR** write a personal check for the amount received. Please forward the payment to the Columbia Outpatient Sedation LLC, PO BOX 200517, Dallas, TX, 75320-0517. We will also require a copy of the original explanation of benefits (EOB) received with your payment.

Columbia Outpatient Sedation participates with some insurance companies. However, we do not participate with all insurance carriers. We will however work closely with your insurance carrier to ensure that you are not penalized for our non-participation in their network. **The max out of pocket for out of network will be \$425.** We are often able to negotiate with your insurer to keep your costs very low, often lower than what you would be responsible for if we were in-network. Some appeal efforts with certain carriers require your direct involvement and cooperation. If needed, we will contact you directly. If you need further explanation, you may call 571-535-2502 and speak with one of our customer services advocates.

Assignment of Benefits and Authorization to Appeal: I authorize payment of medical benefits Columbia Outpatient Sedation. It is my understanding the only charges I may be responsible for are those charges assigned as “patient responsibility” by my insurance company or other third-party payer when Columbia Outpatient Sedation is in-network with insurance. I agree to immediately remit to Columbia Outpatient Sedation any payments I receive directly for services provided. I hereby authorize release of any medical records or information necessary to process insurance claims, appeal benefit determinations, coverage denials, or other adverse decisions on my behalf.

HIPAA Notice: Columbia Outpatient Sedation and Gastro Center of Maryland are business associates. As a result, Columbia Outpatient Sedation may receive, use, obtain, access, or create Protected Health Information from or on behalf of Gastro Center of Maryland while providing anesthesia service. To ensure your privacy and protection, please carefully read the HIPAA information Columbia Outpatient Sedation and Gastro Center of Maryland have provided.

Please retain a copy of this letter for your records in case you need to contact us while your claim(s) is being processed and until it has been satisfied. You will receive an explanation of benefits from your carrier. Please do not make any payments to us until you are notified in writing by Columbia Outpatient Sedation. If you are paid directly by your carrier, please contact us immediately.

Please sign to acknowledge you have read and understand the stated terms and policies. You have been provided the opportunity to ask questions about your financial responsibility and anesthesia care.

Signature _____ Date _____

Print Name _____

FACILITY COPY



Gastro Center of Maryland, LLC
 Cascades Endoscopy Center, LLC | Olney Endoscopy Center, LLC
 Annapolis Endoscopy Center, LLC | Riverdale Endoscopy Center, LLC
 Timonium Endoscopy Center, LLC | Rockville Endoscopy Center, LLC

PATIENT MEDICATION FORM

Name:	Birth Date:
Procedure (s) Scheduled:	
List Allergies and Describe Reaction: <input type="checkbox"/> No Allergies	

List all prescription and over-the-counter (non-prescription) medication taken on a daily basis.
Please include vitamins, aspirin, and herbal preparations.

Name of Medication "Home Medication List as Provided by Patient"	Dose	How Often Taken?	Date Last Taken	<u>PHYSICIAN USE ONLY</u>	
				Resume	Discontinue

New Prescriptions (Given at discharge)

If you have any questions about your home medication, please contact your prescribing physician.



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I have been given the following information, patient bill of rights, billing notice, about advance directives, patient responsibilities, ownership disclosure, and the center's policy on advance directives.

I have read and understand the center's policy on advanced directives, about advance directives, the patient bill of rights, the billing notice to patients, patient responsibilities, and the ownership disclosure.

I, the Patient, agree to have my procedure done at Cascades, Olney, Annapolis, Riverdale, Timonium & Rockville Endoscopy Center, LLC and have read and understand all documents given to me in my procedure packet of information.

Print Patient Name

Patient Signature

Date

Driver's Name*

Driver's Phone Number

*** Drivers-we prefer that you stay in the waiting room or in your car.
Total time in office is usually 1 -2 ½ hours for procedure patients.**