

FAIRFAX COLON & RECTAL SURGICAL CENTER

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Timothy A. Plerhoples, M.D., M.P.H.

SURGICAL CENTER POLICIES

DISCLOSURE OF OWNERSHIP: I have been advised that the following physicians have an ownership interest in the facility: *Dr. Donald Colvin, Dr. Lynda Dougherty, Dr. Daniel Otchy, Dr. Lawrence Stern, Dr. Kimberly Matzie, Dr. Caroline Sanchez, and Dr. Katherine Khalifeh.* A schedule of typical fees for services provided by this facility is available upon request. These procedures are performed at hospitals and other outpatient facilities in this community. I have the right to choose where to receive services, including a facility where my physician does or does not have an ownership interest. I have chosen to be treated at this facility.

ARRIVAL TIME AND PAPERWORK: Unless you are otherwise informed, please arrive 60 minutes before your scheduled procedure in order to complete the admission process. This will help us to keep to the scheduled surgery times. Updating paperwork is required for every visit to the office. In addition, for each visit you will need to have your insurance card and a government issued photo identification. If not already completed in advance of your office visit, registration paperwork can be found on our website on the Registration & Policy Forms link, and submitted in advance of your appointment to speed your check in process.

SCHEDULING/MISSED APPOINTMENTS: Missed procedures/surgical appointments cancelled with less than a 7 day notice and will incur a \$200.00 charge. Abusive missed procedures may result in your dismissal as a patient. Because we are a surgical practice, emergency situations may arise that result in the physician being called away to the operating room. If the physician is unable to perform your procedure as a result of the emergency, he or she may request that another physician in this practice perform your procedure. If you wish to reschedule, every effort will be made to accommodate you.

MEDICAL RECORDS: To obtain copies of your medical records you must sign a Medical Release form. There is a \$10.00 processing fee, plus \$0.50/page. These fees, set forth by Virginia State law, must be paid in full before your request can be processed. Please allow up to two weeks for processing.

FORMS, LETTERS, REPORTS: Disability, workman's compensation, etc... The fee for completion of these items is \$35.00. All fees must be paid in full before the forms can be produced. Please allow at least one week for processing.

YOUR RIDE HOME: You will need a ride to take you to and from our Center for your procedure. You will not be taken back for your procedure until the nurse has confirmed that your driver is in our waiting area. If your ride is not available when you are ready to be discharged a \$100 administrative fee will be assessed.

PRESCRIPTIONS: If for any reason your prescription for medication, CT Scan, MRI, PET scan, etc., needs to be rewritten there will be a \$10.00 charge for a replacement to be called or faxed to a pharmacy or radiologist, or mailed to you. Please utilize our website www.fairfaxcolorectal.com for prescription refills.

FINANCIAL RESPONSIBILITY: If you are having a procedure in our surgical center, you may receive bills from several different providers: the physician performing the procedure, the Ambulatory Surgical Center, Anesthesia providers, and a laboratory if specimens are obtained during your procedure. Please note, because the insurance policy is an agreement between the insured and the insurance company, we expect all patients or their guardian to be fully responsible for knowledge of your insurance benefits, as well as fully and directly responsible for all charges regardless of insurance coverage. Please be assured that we will do everything possible to see that you receive your full benefits in a timely manner. **If your insurance company has not paid their portion of your bill within 60 days, you will be responsible for full payment at that time.**

OUTSTANDING BILLS AND COLLECTIONS: I understand that there will be a 5% late fee for balances not paid when due (within 30 days of the first statement date) unless other arrangements have been made. In addition, in the event my account becomes past due (over 30 days) and arrangements for payment have not been made, my account may be placed for collection. I also understand that I will be responsible for all costs of collection including agency fees, court cost and/or attorney fees. Furthermore, I authorize the collection agency to make calls to my mobile phone number in addition to any other phone numbers associated with my account.

INSURANCE: COPAY, DEDUCTIBLE AND COINSURANCE: Where we have a participating agreement with your insurance company, we will expect your estimated co-payment and/or co-insurance at the time of treatment. We may also request that you pay any outstanding deductible. Contracts with insurance companies do not permit the waiver of these fees under any circumstances. If we do not participate with your insurance company, as a courtesy we will file your claim for you, however, you will be responsible for all charges not covered by insurance. If you do not have insurance, payment in full is due at the time of treatment.

RETURNED CHECK FEE: You will be assessed a \$ 35.00 Returned Check Fee for insufficient funds or closed accounts