Gillian Esser, M.D., F.A.C.O.G.

Gynecology

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Update 05/06/2022

Notice of Privacy Practices Acknowledgement

Thank you for choosing Dr. Gillian Esser as your healthcare provider. She would like to start out by saying welcome to her practice; it is her and her staff's honor to assist in your care needs and our goal to try to make your time at our office the best experience possible.

While it is always better to see you in person, Dr. Esser understands that coming into the office is/may not always be an option with your busy schedule; therefore for some cases she has chosen to offer her patients the opportunity to schedule a phone appointment to discuss your questions or concerns. While most insurance's have begun paying for this, some still do not offer it. Therefore, if your insurance does deny please be aware you will be responsible to pay for that appointment.

We also offer a patient passport portal if you are not already signed up please request the invitation code from reception. This will allow you to message our receptionist, MA, biller or the doctor. Please be aware if the doctor has go over testing and/or make changes to prescriptions ect… this may result in a charge ranging from $40-$80 and is **NOT** billable to your insurance this will be paid by the patient.

Our office also offers food allergy testing that we draw blood and process to send out. We do not bill insurance for this testing as it is not covered, there will be a flat charge of $50.00 in our office for this. The lab that processes the test also has separate charges that will be due to them.

For all other lab draws done in office there is a flat fee of $40.00, the lab we use is labcorp and they will bill your insurance for the processing of the labs. If this results in any patient balance you will receive a separate statement from them. Please understand while most of the labs doctor orders are covered by most insurance plans, we do not contact every plan to see if what is being ordered is covered. You always have the right to contact your insurance prior to the labs being done if you would like to check on your plan.

Dr Esser has decided to offer weight loss, management and nutrition counseling. Please be aware that these visits are not billable to your insurance as the majority of insurances do not recognize weight loss/management as a medically necessary visit. Therefore these visits will be billed as cash pay and will be payable at the time of service. The first visit will be charged at $150 and your follow up visits thereafter will be charged at $100 per visit.

Dr.Esser offers cash discount (not paying via insurance) of 15% for any in-office appointment other than weight loss appointments.

Patient Privacy Statement:

We collect information that is necessary and relevant to provide you with medical care, treatment, and manage our medical practice. This information may include your name, address, date of birth, gender, health information, family history, credit card and contact details. This information may be stored on our computer medical records system and/or in handwritten medical records.

We will treat your personal information as strictly private and confidential. We will only use or disclose it for purposes directly related to your care and treatment, or in ways that you would reasonably expect that we may use it for your ongoing care and treatment.

We will take reasonable steps to ensure that your personal information is accurate, complete and up to date. For this purpose our staff may ask you to confirm that your contact details are correct when you attend a consultation. We request that you let us know if any of the information we hold about you is incorrect or out of date.

None of your personal/private information will be discussed with anyone other than you unless there is written consent on file (**Includes Minors**). Please request the separate form from our front office staff or for minors our Medical Assistant will discuss with you in your new patient exam.

By signing the above policy I am stating that I understand the above information and am agreeing to the office policies and may revoke this consent in writing, except to the extent the office has already taken. I understand that by refusing to sign this consent or revoking Dr. Gillian Esser may refuse to treat me as permitted by section 164.506 of the code of Federal Regulations.

Furthermore with my signature I am stating I understand that Dr. Gillian Esser reserves the right to change this notice prior to implementation, in accordance with section 164.520 of the code of Federal Regulations. Should Dr. Gillian Esser make changes to this notice she will provide an updated copy that will require an updated signature at my next visit.

Signature: _____ Date: _____

Printed Name: _____

Note: If you would like a copy of this notice please request from the front office staff

Patient Financial Responsibility Contract:

This is a legally binding contract between Dr. Gillian Esser and you. The words, *I, me, my, you and your* all refer to the patient. Please initial by each statement:

_____I agree to give Dr. Gillian Esser my complete and accurate insurance information at time of service or as soon as any changes happen. If I fail to give this information this may result in a denial of my claim and I may be responsible for the entire balance.

_____I agree to be financially responsible for payment of Dr. Gillian Esser's services. Cash, check or credit cards are acceptable forms of payment for these services. I understand there will be a $40.00 fee for all returned checks.

_____I agree to pay co-payments and deductibles at the time of service.

_____I agree to pay any balance remaining on my account or contact the billing department to make reasonable payment arrangements upon receipt of my first statement.

_____I understand that if I fail to pay the balance on my account this may result in a bad debt on my account which will require payment in full prior to scheduling any further appointments or could result in the account being forwarded to an outside collection agency and permanent dismissal from the practice. If this happens, I understand I will be responsible for all costs of collections, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

_____I understand that I will be responsible for any missed or cancelled appointments In which I did not provide at least **48 hour notice** and am aware I will be charged a fee of $100.00

_____**I understand that my gynecological annual/well women visit consists of a review of systems, breast and pelvic exam. If there are further concerns/problems that arise I may be asked to return to the office to discuss these concerns. I also may request to change my appointment to deal with my concerns and return on another date for my annual exam.**

Thank you for understanding our payment policy if you have any further questions please contact billing at 360-337-7369.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party: _____

Printed name: ___________________________________ Date: ____________________