GCNS
GASTROENTEROLOGY CONSULTANTS OF THE NORTH SHORE, S.C.

YOLANDRA L. JOHNSON, M.D.
MANOJ K. MEHTA, M.D.
JAMES L. ROSENBERG, M.D.
JONATHAN F. WILLIAMS, D.O.

Thank you for scheduling your procedure or appointment with Dr. Yolandra L. Johnson. We ask that you complete and return the enclosed forms prior to your appointment.

While we do bill all insurances, Dr. Johnson may not be an in-network provider with your plan. **You may wish to contact your insurance company to inquire if Dr. Johnson is in-network.** To ensure accurate billing, our office must be notified of any insurance changes before your appointment. If your insurance company requires a referral or prior authorization, it is important to include a copy with your forms. It is your responsibility to know what your co-pays, co-insurance, or deductibles may be since you are the policy holder.

If you have scheduled a procedure, we have enclosed instructions. **Please read the instructions as soon as you receive them.** There may be some important instructions you have to follow a week before your procedure. There is no need to return the instructions with your forms.

Please be sure to complete and return the following information:

- [x] Complete the Confidential Patient Information forms. We need both pages filled out as much as possible, including the signature at the bottom. Please remember to include the subscriber's information as well.
- [x] Please provide a copy of your insurance card(s), front and back. This is important for billing purposes.
- [x] If you have an HMO or POS, a copy of your referral is needed prior to your appointment.
- [x] Signed Medical Release of Information form.
- [x] **Medicare patients only**—Please include the administrative fee as this is required prior to your procedure.
- [ ] If you are a new patient coming to the office, we ask that you please bring recent medical records from your primary care doctor. This should include blood work, radiology scans, or recent office notes. We would appreciate it if you would please send this information in 2 weeks in advance.

Please mail or fax the above information to our office prior to your appointment or procedure. If you are planning to drop off the information at the office, please let us know ahead of time.

If you need to cancel your appointment, please notify our office at **(847)256-8661** (NOT THE GI LAB) at least 48 hours in advance or a fee may be charged.

It is your responsibility to know and understand your insurance coverage. If Dr. Johnson is not in-network with your insurance, you will be responsible for the bill.

If you have any financial questions, please refer them to the billing manager, our billing staff is trained to discuss your account and make payment arrangements if necessary.

I have reviewed the above letter with full understanding and agree to be personally responsible for payment on my account as stated.

Name (Print)____________________________________

Signature: ____________________________________

Date: ____________________________________

Thank you,

The Office of Dr. Yolandra L. Johnson

YOLANDRA L. JOHNSON, M.D. 506 GREEN BAY ROAD KENILWORTH, IL 60043 PHONE: 847•256•8661 FAX: 847•256•1598
MANOJ K. MEHTA, M.D. 1100 CENTRAL AVE. SUITE H WILMETTE, IL 60091 PHONE: 847•256•1855 FAX: 866•375•3001
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Date: ____________________

Dear Medicare Patient:

Over the years, Medicare has regularly reduced payments for medical services to the extent that current reimbursements are substantially below the cost of providing these services. Medicare continues to warn of substantial reductions in reimbursements to physicians, making the delivery of high quality and timely medical care exceedingly difficult.

We intend to continue to provide high quality, timely and personalized care despite these extreme economic pressures. In order to do so, a fee of $250.00 will be charged to cover the extra administrative expense and processing time for arranging your procedure(s). This fee will not be reimbursed by Medicare or other insurance companies and, therefore, will not be submitted to your insurance for payment. The fee has been reviewed by Medicare and certified that it is being charged for services that Medicare would not cover. It is not in violation of any Medicare guidelines.

We regret the necessity for this fee and hope that you understand its importance for the delivery of the highest quality of care.

Sincerely,

GCNS, S.C.

Please include payment with this form.

I have reviewed the above letter with full understanding and agree to be personally responsible for payment on my account as stated.

Name (Print): ____________________

Signature: ____________________

Date: ____________________

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