GRAND HEALTH PARTNERS
TRANSFORMATIONS HAPPEN DAILY

Bariatric Surgery Payment Responsibilities for Priority Health Medicaid

Service Description	Patient Responsibility
History and Physical w/Internist	$0.00
Visit with Diet and Exercise Physiologist	**$35.00** (for Exercise physiologist)
12 Month Supervised weight loss program (if your insurance requires it)	$0.00
Psychological Evaluation-1st Visit	$0.00
Pre and Post Op Education (2 weeks prior to surgery)	**$105.00 ($35 for Pre-Op visit and $70 for two post-surgery exercise visits**)
Food Supplements	**Approximately $300**

You will need to be on GHP food supplements 2 weeks before and after surgery. Pricing will vary depending on which products are purchased. The average total cost of food is $300. Payment is due at the time of purchase. The product is not returnable or exchangeable. **We encourage you to pay towards your food at each visit so that the cost is more manageable than paying it all at the time of surgery. If you pay $15 to $25 per visit, the funds will be applied as Payer Credit. When you go to the GHP store to purchase your food, you inform the cashier that you would like to use your payer credit to pay for your food. Any excess funds can be applied to outstanding balances or refunded to you via check.**

- The above pricing is to be used as a guideline and may be subject to change based on the physicians' orders/recommendations and insurance carrier processing. Patient will be responsible for any copays/coinsurance, deductibles and denied charges. Contact your insurance to see what your benefit coverage for office visits is.

- Additional charges may be incurred by the hospital and are not covered by our fees. You should contact your insurance company to see what your benefit level and coinsurance is for hospital services

- Laboratory fees are not included in the above pricing. Laboratory fees will be billed to your insurance carrier, however if your insurance does not pay for the lab charges, they will be your responsibility.

I have read this fee agreement and understand that I am responsible for the fees as stated.

Print Name: _____ Date of birth: _____

Patient's Signature: _____ Today's date: _____

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