SAGA San Antonio Gastroenterology Associates & Endoscopy Centers

# Medicare Patient Financial Responsibility Policy

Thank you for choosing Antonio Gastroenterology Associates, P.A. for your healthcare needs. Our Healthcare Providers and Staff are committed to enhancing the quality of your care and overall health. This policy has been designed to inform you of our financial policies and answer any question you may have regarding payment for services rendered at our facilities by members of this group.

If you have insurance, San Antonio Gastroenterology Associates, P.A. will help you to receive maximum benefits by filing a claim for you. If you have a deductible, co-pay or co-insurance, payment arrangements will be made prior to your visit or the day of your visit. You are expected to follow the rules of your carrier in obtaining pre-authorization or referrals. Any non-covered amounts will be the patients' responsibility and billed to the responsible party.

If Medicare/Medicaid, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the social security administration or its intermediaries or carriers any information needed for this or related Medicare/Medicaid claims. I request that payment or authorized benefits be made on my behalf, to San Antonio Gastroenterology Associates, P.A. I understand that I am responsible for my health insurance deductibles and co-insurance.

If Medigap, I request that payment of authorized Medigap benefits be made on my behalf
San Antonio Gastroenterology Associates, P.A. for any physician's services. I authorize any holder of medical or other information about me to release to
_____ any information needed to determine these benefits.

The Undersign certifies that he/she has read the forgoing, received a copy thereof, and the patient, the patient's legal guardian or the patients authorized representative accepts its terms. I also understand that a photocopy of this release is as valid as the original. This agreement is valid for the duration of the claims and appeals process but not to exceed two (2) years.

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Signature of Patient or Legal guardian or Authorized Representative Date

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Relationship to Patient Time