



Patient Financial Responsibility Policy

Thank you for choosing *San 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 questions 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 patient's responsibility and billed to the responsible party.

If you do not have insurance, payment arrangements will be made prior to your visit or the day of your visit. If requested, an estimated price quote of charges for your visit will be given.

Assignment of Benefits

I hereby assign benefits to be paid, on my behalf, to *San Antonio Gastroenterology Associates, P.A.*

I understand and agree to be financially responsible for charges not paid within a reasonable period of time by insurance or third-party payer and certify that the information given with regard to insurance coverage is correct.

I agree that payment for all charges incurred are the primary responsibility of the patient or the patient's responsible party. I authorize *San Antonio Gastroenterology Associates, P.A.* or its agents to verify the patient's insurance coverage and employment.

The undersign certifies that he/she has read the foregoing, received a copy thereof, and the patient, the patient's legal guardian, or the patient's authorized representative accepts it's 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