SAGA San Antonio Gastroenterology Associates & Endoscopy Centers

520 East Euclid Avenue
San Antonio, TX 78212

Financial Agreement-Assignment of Benefits

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. Our insurance contracts require us to collect deductibles, coinsurance and copays. If you have a deductible, co-pay or co-insurance, payments can be collected prior to your visit or the day of your visit. For your convenience we accept Visa, MasterCard, Discover and American Express. You are expected to follow the guidelines of your carrier in obtaining pre-authorization or referrals. In the event that your health plan determines that a service is "not covered" you will be responsible for the entire balance.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to San Antonio Gastroenterology Associates, P.A. for services rendered to myself and/or my dependents. I understand I am responsible for any services not covered by insurance.

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.

_____ _____

Signature of Patient or Legal Guardian or Authorized Representative | Date

_____ _____

Relationship to Patient | Time