PATIENT (MEDICARE/MEDICAID/COMMERCIAL) FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Heart and Vascular Clinic of San Antonio, PLLC 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, Heart and Vascular Clinic of San Antonio, PLLC will help you to receive maximum benefits by filing a claim for you. If you have a deductible, co-pay, or coinsurance, payment arrangements will be made prior to 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.

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If **MEDICARE/MEDICAID/COMMERCIAL** insurance, I certify that the information given by me in applying for the 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 of authorized benefits be made on my behalf to Heart and Vascular Clinic of San Antonio, PLLC. 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 to Heart and Vascular Clinic of San Antonio, PLLC for any physician's services. I authorize any holder of medical information about me to release to Heart and Vascular Clinic of San Antonio PLLC, for any information needed to receive these benefits.

The undersigned certifies that I have read the above terms, and I, my legal guardian, or my authorized representative accepts the above terms. I also understand that a photocopy of this release is as valid as the original. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Patient or Legal Guardian or Authorized Representative Date

_____ _____

Relationship to Patient Date