Medicare Patient Financial Responsibility Policy

Colorectal Surgery Services, PLLC
Hemorrhoid Institute of South Texas

Thank you for choosing Colorectal Surgery Services, 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 clinic by our physician provider.

If you have insurance, Colorectal Surgery Services, PLLC 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 are to 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 requested, an estimated price quote of charges for your visit will be given.

If you fail to give us a 24-hour notice of cancellation of a visit, there will be a $25.00 cancellation fee billed to your account that is non-covered by your insurance. You will bear complete financial responsibility for this fee. Repeated missed appointments may result in dismissal from our practice. This may include a fee of $250.00 for cancellation of any surgery or procedures without a 24 hour notice.

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 of authorized benefits be made on my behalf, to Colorectal Surgery Services, 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 Colorectal Surgery Services, PLLC for any physician's services. I authorize any holder of medical or other _____
any information needed to determine these benefits.

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 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.

_____ _____
Signature of Patient or Legal Guardian or Authorized Representative Date

_____ _____
Relationship to Patient Date