Digestive and Liver Disease
Center of San Antonio

Setting the standard of quality, personalized care.

Robert M. Narváez, MD, MBA

FINANCIAL POLICY

We are committed to providing you with the best possible medical care. Collection and credit policies are a necessary part of assuring the health care service we provide our patients. In order to achieve this, your assistance and your understanding of our payment policy is important.

Charges for initial consultations, subsequent follow-up visits, and other treatments are due and payable at the time services are rendered.

We accept the following:

* Cash, personal checks, and money orders

* American Express, MasterCard, and Visa

If a check is returned from your bank as insufficient, we will require that you make payment in cash. In addition, a Service fee will be added to your balance of $35.00.

If you have private insurance, we will gladly discuss your proposed plan of medical treatment and answer any questions as it relates to your insurance plan. **HOWEVER, YOU MUST REALIZE THE FOLLOWING:**

1. Your insurance policy is a contract between you and your insurance company. <u>WE ARE NOT A PARTY TO THAT CONTRACT.</u>

2. While we do file insurance claims for our patients as a courtesy to your insurance company, any charges not covered by your insurance plan, such as deductibles, co-insurance amounts, and any other non-covered amounts are your responsibility.

We must emphasize that as medical care providers, our relationship is with you and NOT your insurance carrier.

It is the policy of this office that accounts 60 days or older be referred to our collections agency.

If financial problems arise, we encourage you to contact us immediately.

Should you have any problems complying with our financial policy or have any questions regarding this financial agreement, it is important that you bring your questions to us prior to your receiving medical treatment; that way there are no misunderstandings.

I understand and agree with the Financial Agreement above.

X ____ Date ______________________________

MEDICAL RELEASE FORM

Please release my entire medical records to:

Dr. Robert M. Narváez
12602 Toepperwein Road
San Antonio, Texas 78233
(210) 650-9119

I ____, do hereby authorize the release of my entire medical records file to the person listed above without holding **Dr. Robert M. Narváez, M.D., MBA** liable for the said release of records.

____ ______________________________
Patient Signature Date

ACKOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of Patient of Personal Representative

____
Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority