



Integral Gastroenterology Center, P.A.
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Spring, TX 77388
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Authorization for Payment and Medical Treatment

As a result of our sincere desire to base all medical decisions on what is best for the patient, not what is best for the insurance company, we are no longer contracted with any insurance carriers.

1. All charges must be paid at or before the time of service. For your convenience, we accept cash, check, and all major credit cards.
2. To keep the credit card information current, you authorize us to securely store your credit card information, and only charge it should you have an outstanding balance. The storage system used is fully compliant to the highest level of credit card storage security regulations. Once stored, only the last five digits of your credit card are viewable by us.
3. The contract with your insurance company to pay for a portion of your medical care is between you and your insurance company. By eliminating costs associated with billing, coding diagnoses and procedures, referrals, authorizations, payment delays, explanation-of-benefits reviews, claim denials, re-submissions, collection risks, and other managed care costs, we can provide patients a fair price for services without the administrative hassles and bureaucracy.
4. For your benefit, we will always provide you with a list of our fees and billing codes before any services are performed. We recommend you contact your insurance carrier to verify your benefits so you will have a basic understanding of how your insurance will reimburse you for services provided by our office. Unfortunately, insurance carriers are not always willing to provide their allowable fees or disclose which billing codes they will cover. If this is the case, you may want to contact the Texas Department of Insurance:
www.tdi.state.tx.us/health/index.html
5. It is your responsibility to obtain all referrals/authorizations required by your insurance plan and to file your claim with your referral/authorization.
6. You will be given a completed claim form (and a duplicate copy for your records) with all the codes necessary for you to file a claim with your insurance carrier. We recommend you contact your insurance carrier and request instructions for filing your claims.
7. Due to rising administrative costs and the numerous requests we receive, our office does not fill out "forms" from insurance companies. A copy of the patient's medical records will be

forwarded to the insurance company when a signed authorization to release medical records is received. Its medical review professionals can extract the information required from these records.

8. This is a professional office that renders quality care to patients, and our entire staff is exceptional. Our service is superb. Our duty is to preserve the dignity and confidentiality of our patients while receiving appropriate payment for the medical care we have provided. Nothing about our practice is “usual” or “customary” – terms employed to justify the comparison of our fees, designed to provide for complex medical diagnosis and treatment with superior equipment, to those allowed by outdated insurance fee schedules.

9. Medicare:

Dr. Venodhar Julapalli has chosen to “Opt Out” of Medicare. All patients who are on Medicare, or are eligible for Medicare, must sign the federally mandated “Private Contract” in order to receive services at our clinic. All services must be paid at or before the time of service, and neither Dr. Julapalli nor the patient may file a claim to Medicare for reimbursement

10. Medicaid:

We are not accepting any Medicaid patients. We will only accept “Private Pay” patients. We will not file any claims to Medicaid for reimbursement of your medical services now or at any time in the future.

I, the patient identified below or the patient’s legally authorized representative, have read, understand and agree to the terms and conditions listed above.

I/the patient’s legally authorized representative consent to medical treatment which may be performed by Integral Gastroenterology Center, P.A., including but not limited to diagnostic tests, procedures related to the gastrointestinal tract, x-ray examination and laboratory procedures such as testing of blood or other bodily fluids to determine the presence of any communicable disease such as, to the extent allowed by law, Hepatitis and Human Immunodeficiency Virus (the causative agent of AIDS). I further consent to my/the patient’s physician performing or administering all tests, services, or treatments indicated as previously described. I understand any invasive procedures will require a separate informed consent form.

Signature

Relationship (if not the Patient)

Date