COVID-19 FORM

I understand that Practice is in-network with my health insurance plan and I am receiving non COVID-related healthcare items and services. As such, I will be financially responsible for my cost-sharing portion associated with the services I receive, including, but not limited to deductible amounts, copayments, or payment for services deemed not covered by my health insurance plan.

Patient Initials: _______

I understand that Practice is in-network with my health insurance plan and I am receiving COVID-related healthcare items and services. Pursuant to the Family First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), my health insurance plan is responsible for covering 100% of these items and services and I should not be responsible for any cost-sharing obligation. However, in the event my healthcare insurance plan does not cover all or any portion of these services, I will be financially responsible for any outstanding amounts.

Patient Initials: _______

I understand that Practice is out-of-network with my health insurance plan and I am receiving non-COVID-related healthcare items and services. As such, I understand that I will be "balance billed" and will be financially responsible for my cost-sharing portion associated with the services I receive, including, but not limited to deductible amounts, copayments, or payment for services deemed not covered by my health insurance plan.

Patient Initials: _______

I understand that Practice is out-of-network with my health insurance plan and I am receiving COVID-related healthcare items and services. Pursuant to the FFCRA and the CARES Act, my health insurance plan is responsible for covering 100% of these items and services and I should not be responsible for any cost-sharing obligation. In the event my health insurance plan determines I am responsible for any cost-sharing obligation, Practice will only charge me an amount equal to the cost-sharing obligation if Practice was in-network with my health insurance carrier. In the event my healthcare insurance carrier deems the services non-covered or not payable, I will be responsible for the cost of such services.

Patient Initials: _______

I am uninsured and will be responsible for full payment of the medical services rendered to me at the time of service.

Patient Initials: _______

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16110 Via Shavano
San Antonio, Texas 78249

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12415 Bandera Rd., Ste. 114
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