HOUSTON HOSPITAL FOR SPECIALIZED SURGERY

Patient's Name: _____ Medicare#: _____

NOTICE TO BENEFICIARIES OF COINSURANCE LIABILITY

This facility is now an outpatient department of Houston Hospital for Specialized Surgery. When you receive services at this facility, you will receive two separate bills – one for the facility component of your services (which will be billed by the hospital) and one for the physician/professional service (which will be billed by Physician Services). The higher total coinsurance amount is based on Medicare's prescribed coinsurance rates for each of the two components. Standard Medicare supplement policies pay all or a portion of these coinsurances based on their contract terms.

If you are covered through a Medicare Advantage Plan (Part C) you may have to pay a coinsurance, co-payment or deductible amount for the facility services that you receive in addition to your physician co-payment or coinsurance. This amount may be higher than the coinsurance owed under traditional Medicare coverage. To find out your responsibility, please contact your Medicare Advantage Plan.

We are required to give you this notice before delivering health care services to you unless you are seeking treatment for an emergency medical condition and we have not yet ruled one out or stabilized the condition.

If you have any questions concerning this notice, our Patient Service Representatives in this office will be happy to assist you. If you have question regarding your coinsurance, co-payment or deductible, you may also call the HHSS Billing Department at (713) 528-6800.

Finally, please understand that this notice is different from the advance beneficiary notice (ABN) that Medicare requires us to give patients to notify them of their responsibility to pay for services that Medicare is not likely to cover. Instead, this is a notice that you will have to pay a portion of the cost of services that Medicare does cover.

The actual coinsurance amount will depend on the services you receive.

	Low Estimate	High Estimate
Office Visits	$15.00	$30.00

Please acknowledge receipt of this notice by signing and dating below:

_____ _____
Patient's Signature Date and Time

_____ _____ _____
Legal Representative Name/Relationship to patient Legal Representative Signature Date and Time

People assisting with paperwork:

_____ _____ _____
Interpreter's name Interpreter's Signature and/or ID # Date and Time

_____ _____ _____
Office Staff name Office Staff Signature Date and Time

NOTE: **Your health information will be kept confidential**. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Medicare will keep your health information, which Medicare sees, confidential.

Place patient sticker here or handwrite

Name: _____

DOB: _____