Houston Gastrointestinal & Liver Clinic, P.A.
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Insurance Information Form

Patient Name: ____ Date of Service: __________
First Name Last Name MI

PRIMARY INSURANCE CARRIER

Insurance Name: ____

Member ID #: ___________________________________ Group #: ____________________

Insured's Name: __________________________________ Insured's SS #: _______________

Insured's DOB: __________________ Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

SECONDARY INSURANCE CARRIER

Insurance Name: ____

Member ID #: ___________________________________ Group #: ____________________

Insured's Name: __________________________________ Insured's SS #: _______________

Insured's DOB: __________________ Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

- I understand that I am required to give current insurance card, photo ID, and other billing information for claims to be filed to any contracted carriers on my behalf. I agree to notify Houston Gastrointestinal & Liver Clinic, P.A. of any changes in my insurance coverage or statement address and contact information as soon as possible.
- I authorize payment of medical benefits be made directly to Houston Gastrointestinal & Liver Clinic, P.A. for services rendered. This assignment covers any and all benefits under Medicare, private insurance, other government sponsored programs, and any other health plans.
- In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Houston Gastrointestinal & Liver Clinic, P.A.
- I understand that I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf.
- I authorize Houston Gastrointestinal & Liver Clinic, P.A. to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred.
- I understand that I have the right to request and receive a Notice of Privacy Practices from Houston Gastrointestinal & Liver Clinic, P.A.

THIS AGREEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

Patient Signature: ____ Date: ____________________

*****PLEASE COMPLETE ALL PAGES*****