Houston Gastrointestinal & Liver Clinic, P.A.
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Patient Agreement Form

CONSENT TO TREAT: I hereby authorize Houston Gastrointestinal & Liver Clinic, P.A. to examine me/the patient named below and to furnish such diagnostic and therapeutic services as they deem necessary and appropriate. If I am authorizing on behalf of someone other than myself such examination and services may be provided in my absence.

FINANCIAL RESPONSIBILITY: I understand that I am responsible for all services rendered at the doctor's regular rates. If, however, insurance benefits are assigned to the doctor and billed to the insurer, I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer. I understand and agree that it is my responsibility to obtain any prior approval required by my insurer, and to take all other steps to qualify for insurance coverage. I agree that all charges are due upon billing. I agree that if referred to a collection agency or legal action is necessary to collect my balance; I will pay the doctors' reasonable attorney fees and costs of collection. No extension or forbearance, and no attempt to obtain payment from insurance or other sources, shall waive or release my financial obligations under this agreement.

ASSIGNMENT OF BENEFITS: I hereby allow Houston Gastrointestinal & Liver Clinic, P.A. to receive payment of insurance benefits for services provided by the doctor, their employees or others working under contract. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient of the undersigned.

RELEASE OF INFORMATION: I authorize the release and disclosure of all or any part of my medical records to any person or entity (or representative thereof) which may be responsible to pay for any portion of the charge incurred, including but not further authorize release to any physicians, hospitals, or others who may require such records in connection with my current or subsequent health care. I also authorize Houston Gastrointestinal & Liver Clinic, P.A. to obtain medical records from other sources I needed for my medical care. A photocopy of this release shall be considered valid. No person or entity shall be liable for disclosing records in the good faith belief that disclosure is authorized by this release. This release may or may not be revoked as to any records relating to services provided during this course of treatment.

BY SIGNING BELOW, I obligate the patient, and personally obligate myself if I am the patient or the patient's spouse or parent, to all of the terms set forth herein. This Agreement shall remain valid for all subsequent visits and all services after this date unless expressly revoked. **I HAVE READ THIS DOCUMENT OR IT HAS BEEN READ TO ME. I UNDERSTAND AND VOLUNTARILY ACCEPT ITS TERMS, IF I AM SIGNING FOR SOMEONE ELSE, I CERTIFY THAT I HAVE LEGAL AUTHORITY TO DO SO.**

Patient Name: ____ Date of Birth: ______________

Patient Signature: ____ Date: ____________________

IF RESPONSIBLE PERSON IS SOMEONE OTHER THAN THE PATIENT, SPOUSE, OR PARENT:
The undersigned, who is a person other than the patient, patient's spouse, or patient's parent, individually agrees to be personally responsible for the financial obligations set forth above, and personally guarantees payment of all charges.

Signature of Responsible Party: _____________________________ Relationship to Patient: _________________

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