

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

POLICY/MEMBER ID#: _____ **GROUP#** _____

INSURANCE PHONE # _____ **POLICY HOLDER:** _____

RELATIONSHIP: _____ **EMPLOYER** _____

SECONDARY INSURANCE _____

POLICY #: _____ **GROUP#** _____

INSURANCE PHONE# _____ **POLICY HOLDER:** _____

MEDICAID # (IF APPLICABLE) _____

FINANCIAL INFORMATION

OUR OFFICE POLICY IS TO COLLECT PAYMENT BEFORE SERVICES ARE RENDERED. ALL COPAY, DEDUCTIBLE, AND COINSURANCE AMOUNTS SHOULD BE PAID TO THE RECEPTIONIST AT CHECK-IN.

All professional services rendered are charged to the patient. We will assist you with insurance reimbursement; however the patient is ultimately responsible for all fees regardless of insurance coverage. It is our policy to request payment at the time of service unless other arrangements have been made in advance. If you have questions about fees, please ask the receptionist before being seen.

I assign to West Georgia Gastroenterology Associates, P.C., Inc. all payments for medical services including major medical benefits rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance. I authorize West Georgia Gastroenterology Associates, P.C., Inc. to furnish information to insurance carriers, physicians, or hospitals concerning my illness and treatments. I authorize any physician, hospital, or medical care facility to provide all information on medical history and treatment to West Georgia Gastroenterology Associates, P.C., Inc., and I authorize photocopies of this form to be as valid as the original. In the event that my records need to be faxed for any reason and are accidentally misdirected, I release West Georgia Gastroenterology Associates, P.C., Inc. from any liability. I have read and understand the above and give West Georgia Gastroenterology Associates, P.C., Inc. permission to treat me/my child.

SIGNED: _____ **DATE:** _____