

# Endoscopy Center at Central Park

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ SS# \_\_\_\_\_ M/F \_\_\_\_\_ Home Phone \_\_\_\_\_

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Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_

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Spouse/Parent \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Name \_\_\_\_\_ Address \_\_\_\_\_

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**Primary Insurance** \_\_\_\_\_ Insured's Name \_\_\_\_\_

DOB \_\_\_\_\_ SS# \_\_\_\_\_

Claims Address \_\_\_\_\_

Group/Policy # \_\_\_\_\_ ID # \_\_\_\_\_

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**Secondary Insurance** \_\_\_\_\_ Insured's Name \_\_\_\_\_

DOB \_\_\_\_\_ SS# \_\_\_\_\_

Claims Address \_\_\_\_\_

Group/Policy# \_\_\_\_\_ ID# \_\_\_\_\_

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Referring Physician \_\_\_\_\_ Pharmacy # \_\_\_\_\_

I request that payment under the above named insurance program be made payable to:

**Endoscopy Center at Central Park, 1600 Central Drive, Suite 300, Bedford, TX 76022**

on any bills for services rendered to me. I understand that any portion not paid by my insurance company is payable by me. I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the center of any insurance changes that I am responsible for all facility fees.

I also authorize the center to release any information acquired in the course of my procedure. I agree that a photographic copy of this authorization shall be as valid as the original.

I understand that without my signature, my insurance cannot be filled and no reports can be released to my Referring Physician. I have received the Notice of Privacy Practices information.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**NOTE:** The Endoscopy Center bills separately from the Doctor.

There will be two separate bills for your procedure. If you have a biopsy taken, you will also receive a bill from the Pathologist.

***If this form is not COMPLETELY filled out, your insurance can not be filed.***