

OldTown endoscopy center

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Age _____ SS# _____ M/F _____ Home Phone _____

Employer _____ Occupation _____

Address _____ Work Phone _____

Spouse/Parent _____ Work Phone _____

Employer Name _____ Address _____

Primary Insurance _____ Insured's Name _____

DOB _____ SS# _____

Claims Address _____

Group/Policy # _____ ID # _____

Secondary Insurance _____ Insured's Name _____

DOB _____ SS# _____

Claims Address _____

Group/Policy# _____ ID# _____

Referring Physician _____ Pharmacy # _____

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

Old Town Endoscopy Center, 5500 Greenville Ave., Suite 1100, Dallas, TX 75206

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.