Endoscopy Center at Redbird Square

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 ____________________

Insured's DOB ____________________ Insured's SS# ____________________

Claims Address ____________________

Group/Policy # ____________________ ID # ____________________

Secondary Insurance ____________________ Insured's Name ____________________

Insured's DOB ____________________ Insured's SS# ____________________

Claims Address ____________________

Group/Policy# ____________________ ID# ____________________

Primary Care Physician ____________________

I request that payment under the above named insurance program be made payable to:
Endoscopy Center at Redbird Square 3107 W.Camp Wisdom, Suite 189, Dallas, TX 75237
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 to my insurance company any information acquired in the course of my procedure. I agree that a photographic copy of this signed authorization shall be as valid as the original. 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.