GASTROENTEROLOGY CLINIC OF SAN ANTONIO, P.A.

8550 Datapoint Dr., Ste.200 San Antonio, TX. 78229
Telephone (210) 615-8308 Fax (210) 615-8313

PATIENT INFORMATION & AGREEMENT

Name______________________________ Date____________

Date of Birth________________________ M___F___ SS#__________________

Address____

City _________________________________Zip Code_________________________

Home Phone ____________________Cell# ___________________________

Email: _____________________

Preferred Method of Contact: Text__________ Cell ____________Email____________

Occupation ____

Primary Care Physician __________________________Phone# _______________

Referred by Dr. ________________________________Phone# _______________

Insurance Carrier_____________________ID#________________________________

Name of Insured_______________________________ Dob____________________

Secondary Carrier _____________________ID#__________________________________

Emergency Contact: ____________________________Phone# ________________

Assignment of benefits: I hereby assign all medical and or surgical benefits, to which I am entitled, including Medicare, Medicaid and private medical insurances and other health plan to GCSA. This assignment will remain in effect until revoked by me in writing. Photocopy of this agreement is as valid as the original. I authorize assignee to release all information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance. I authorize the release of any medical information to any physician (PCP referring) and /or insurance company as it relates to my continuation of care. I hereby consent to the use of my contact information and email for the purposes of receiving health related material from my physician's office.

Patient's Signature______________________________ Date ____________________

UPDATED 05/01/2019