Insurance Authorization and Financial Responsibility Disclosure

By signing below, I authorize Tucson Gastroenterology Institute to release any medical information necessary to process mine or my dependents insurance claim. I authorize any benefits due to be paid directly to Tucson Gastroenterology institute.

Your insurance company only provides our office an “estimate” of covered benefits prior to receiving any services. The “estimate” is not a guarantee of benefits. I understand that I may be required to provide a referral/authorization from my primary care provider if needed by my insurance. I also understand that I may also be required to pay a deductible, co-pay, co-insurance, or any balance not covered by my insurance. In the event that my insurance does not pay for services, I agree that I am responsible for payment balances.

I understand that all fees shall be paid at the time of service. Unsettled balances will may be referred to an outside collection agency. Returned checks will be subject to additional fees.

Patient/ Guarantor Signature _____

Date _____

Tucson Gastroenterology Specialists, P.C.
3040 N. Swan Road. Suite B. Tucson, AZ 85712
(520) 327-3454
Please visit us at: www.tucsongastro.com

Authorization to Schedule Testing/Discuss Test Results

Patient Name: _____ DOB: _____

I authorize Tucson Gastroenterology Specialists, PC to talk to the following people regarding scheduling of my testing or my test results if I am unavailable: **(please check all that apply)**

( ) No one other than myself

( ) Name of Person Other Than Myself _____

( ) It is okay to leave a detailed voicemail on my personal/home phone.

I understand that this statement will remain in effect until I notify the office in writing on a form provided by this office of any changes.

_____ _____

Patient Signature Date

Emergency Contact Information

Name: _____ Relationship: _____

Contact Phone Number(s): _____

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