

Southwest Digestive Specialists

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Insurance Form

Referring Physician _____ Date _____

Patient Name _____ Spouse _____

Address _____ City/State/Zip _____

Home Phone _____ Cell _____ Work _____

Occupation _____ Employer _____

Patient Social Security Number _____ Date of Birth _____

Emergency Contact Name _____ Phone _____

Relationship of Emergency Contact _____

Primary Insurance Company _____

Secondary Insurance _____

Read the following information carefully and sign below:

Medicare care is based upon mutual understanding and confidence. You may discuss with the physician any questions regarding fees. Our billing service will assist in filing your insurance. **You, the patient, are responsible for your medical bill.** It is your responsibility to contact your insurance company prior to your office visit or procedure(s) to ensure your coverage benefits. Southwest Digestive Specialists will pre-certify your procedures. This pre-certification does not guarantee coverage or benefits.

RELEASE OF INFORMATION REGARDING TEST/PROCEDURE RESULTS:

Who may receive information regarding your Protected Health Information? (list all that apply)

Spouse – Name and DOB _____

Children – Names and DOB _____

Significant Other/Friend – Name and DOB _____

May we leave messages regarding test results and appointments on your voice mail? _____

Patient Signature _____ Date _____