GREATER HOUSTON FAMILY MEDICINE

100 MEDICAL CENTER BLVD., SUITE #104

CONROE, TX 77304

(936) 756-2888

"I, _____

REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO GREATER HOUSTON FAMILY MEDICINE FOR ANY SERVICES FURNISHED ME BY SAID PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER AND/OR ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I AGREE AND UNDERSTAND THAT I AM RESPONSIBLE FINANCIALLY TO GREATER HOUSTON FAMILY MEDICINE FOR ALL CHARGES INCURRED BY ME WHICH ARE NOT PAID BY MY INSURANCE CARRIER, FOR WHATEVER REASON. WHILE I UNDERSTAND THAT GREATER HOUSTON FAMILY MEDICINE MAY BILL MY INSURANCE COMPANY FOR ME AS A COURTESY, I AGREE THAT THIS SERVICE IN NO WAY RELIEVES ME OF MY OBLIGATION TO PAY GREATER HOUSTON FAMILY MEDICINE FOR HIS SERVICES IN FULL. I FURTHER AGREE THAT I WILL PROMPTLY PAY THE BALANCE OF ANY AMOUNTS OWING TO GREATER HOUSTON FAMILY MEDICINE. AS A RESULT OF THE FAILURE AND/OR REFUSAL, FOR WHATEVER REASON, OF MY INSURANCE CARRIER TO PAY MY BILL TO THIS OFFICE WITHIN SIXTY (60) DAYS.

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO GREATER HOUSTON FAMILY MEDICINE AND I FURTHER AUTHORIZE THE RELASE OF ANY AND ALL INFORMATION CONCERNING MY ILLNESS OR INJURY TO MY DESIGNATED INSURANCE CARRIER

I UNDERSTAND THAT MY APPOINTMENT TIME IS RESERVED ESPECIALLY FOR ME AND I MUST GIVE THIS OFFICE NO LESS THAN 24 HOURS NOTICE OF CANCELLATION OR I WILL BE CHARGED $40.00 FOR EACH MISSED APPOINTMENT (MORE FOR AN ANNUAL OR STRESS TEST).

I HAVE READ AND FULLY UNDERSTAND THE ABOVE-DESCRIBED POLICIES OF GREATER HOUSTON FAMILY MEDICINE.

PATIENT SIGNATURE: _____

DATE: _____ 20, _____