



COLORECTAL SURGICAL ASSOCIATES, LTD, L.L.P.  
 PHONE: 713.790.0600 FAX: 713.790.0616

**PATIENT INFORMATION FORM**

Chief Complaint \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Today's date: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status \_\_\_\_\_ Sex: Male or Female  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Social Security: \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Phone number \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Phone number \_\_\_\_\_  
 Are you under the care of any physician not listed above? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Physician Name: \_\_\_\_\_ Phone number \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION**

***Primary***

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 Insured's Name \_\_\_\_\_ Rel to Pt \_\_\_\_\_  
 Insured's DOB \_\_\_\_\_ ID/Member No \_\_\_\_\_ Grp No \_\_\_\_\_

***Secondary***

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 Insured's Name \_\_\_\_\_ Rel to Pt \_\_\_\_\_  
 Insured's DOB \_\_\_\_\_ ID/Member No \_\_\_\_\_ Grp No \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I hereby authorize payment of benefits directly to the physician for the surgical and/or medical services herein specified. I am aware of my responsibility to pay any non-covered service, as well as any co-pay, co-insurance, and/or deductible due at the time of treatment.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date



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### Financial Policy

**Please read all of the information contained in this document. We will be glad to answer any questions concerning your financial responsibilities.**

We take assignment of benefits on all Insurance Carriers that we are contracted with and submit your claim information to these carriers on your behalf.

We are required to collect all Co-payments and past due balances at the time of service. As part of your evaluation today, our physicians may perform an exam or procedure which some insurance companies apply towards your annual Deductible and Co-insurance. Deductibles and Co-Insurance amounts will also be collected when scheduling surgeries or procedures. There is a \$50.00 fee charged for cancellation of scheduled surgeries or procedures less than 48 hours prior to scheduled date.

Patients with HMO plans that require a referral or authorization for a Specialist must obtain the appropriate referral from their referring physician’s office. Our office must have the referral before your visit with a CSA physician.

It is the patient’s responsibility to give our office the correct Insurance information and to keep us updated if changes are made to your insurance. A copy of your Insurance card and Driver’s license will be made for your chart. If the Insurance information is not accurate and updated, you may be responsible for all charges.

I have read and understand the above policies and have received a copy of the Notice of Privacy Practices from the office of Colorectal Surgical Associates, Ltd. LLP, and by signing below I agree to the terms set forth in this document. I also assume full responsibility for my account and will assist in receiving payments from my Insurance carriers if needed.

Please note: Verification of benefits does not guarantee payment; this is only a quote from your insurance company. You are ultimately responsible for the charges.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date