TEXAS GULF COAST
medical systems

AUTHORIZATION FOR SERVICE

Fillable Form

PHONE: (281) 604-1300 FAX: (281) 724-0355

NOTE: This form can be filled out from your screen. Just click in the open space beside each query and type in the requested info.

You can click "Highlight Fields" in the top right corner of your PDF Reader to view all the fillable areas. Click the 'email' and/or 'print' button(s) above when finished.

ADULT

ASSIGNMENT AND RELEASE

I, the undersigned have insurance coverage with _____ and assign directly to Texas Gulf Coast Medical Group (TGCMG) all medical benefits, if any, otherwise payable to me for services rendered. I authorize TGCMG to furnish information to insurance carriers, *including Medicare or Medicard concerning my illness. This information will contain treatment records, medication records, laboratory reports, history and physical examination and information related to communicable disease and will be used for insurance payment purposes. This authorization is valid until I revoke it. I have the right to refuse release of information or to revoke this release. If I refuse to release this information, I understand that I am financially responsible for all charges and must pay for services at the time of delivery.* I further understand that I have financial responsibility for all services whether or not paid by insurance. It is my responsibility to verify whether TGCMG is part of my provider network and/or I am assigned to TGCMG.

I hereby authorize the use of my signature on all insurance submissions.

X _____ ☐ Yes ☐ No

Signature of Patient, Guarantor or Guardian Date

MEDICARE & MEDICAID AUTHORIZATION

I request that payment of authorized Medicare or Medicaid benefits be made on my behalf to Texas Gulf Coast Medical Group for any services furnished to me by physicians of the group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary for CMS or the Medicaid payer to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. The physician agrees to accept the charge determination of the Medicare carrier as the full charge and I agree to be responsible only for the deductible, coinsurance or non-covered services. Coinsurance and deductible amounts are based on the charge determination of the Medicare carrier. The physician agrees to accept Medicaid payments in accordance with Medicaid regulations as payment.

X _____

Signature of Patient, Guarantor or Guardian Date

IF MEDICAID, I attest that I am (or) _____(name of patient) is eligible for services under the Medicaid program and agree to pay TGCMG in the event Medicaid determines me to be ineligible for services provided by the physicians of TGCMG.

TREATMENT AUTHORIZATION

I authorize Texas Gulf Coast Medical Group to give me or _____(name of patient) reasonable and proper medical care by today's standards. *I understand that a medical record will be developed for treatment purposes and that this record may be used for Treatment, Payment and Operations at TGCMG.*

X _____

Signature of Patient, Guarantor or Guardian Date

GUARDIAN

I certify that I am the legal guardian of_____, an adult and as such am authorized to sign on his/her behalf.

X _____

Signature of Guardian Date

LABORATORY INSURANCE CONSENT

I authorize and give Texas Gulf Coast Medical Group my consent to submit specimens (blood tissue, etc.) to the laborator(ies) of choice for analyses and study. This authorization includes submission for payment to my insurance company, including Medicare and Medicaid, and/or me for charges incurred and agree to full responsibility and payment of any non-covered medical services. *Medicare requires notification via an Acknowledgement of Benefit Notification (ABN) for non-covered laboratory testing. This authorization is effective until I revoke it. I have the right to refuse this release of information. If I refuse to release the information, I understand that I cannot be provided benefits under my insurance, Medicare or Medicaid and the laboratory will require payment for services at the time of service. My signature requests that payment be made to the authorized laboratory and authorizes release of medical information necessary to pay the claim.*

X _____ ☐ Yes ☐ No

Signature of Patient, Guarantor or Guardian Date

RESPONSIBLE PARTY AGREEMENT

I,_____ guarantor of this account, agree to pay the balance due. Should the collections department need to contact me regarding this account and are unable to reach me by mail or home phone, then I may be reached at my work phone.

X _____

Signature of Guarantor

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Print Form