

G.I. MEDICINE ASSOC., P.C.
MOHAMMED BARAWI, M.D.
RICHARD A. CASCIO JR., M.D.
SATYAJIT DANIEL, M.D.
SUDHANSHU H. PATEL, M.D., F.A.C.P.
KETAN G. RANA, M.D., F.A.C.G.
VALIYA V. RAVI, M.D.
ROBERT VENERI, M.D., F.A.C.P., F.A.C.G.
IRENA ZALEWSKA, M.D.
BARBARA LAWSON, RN, MSN, NP-C
LENORE RANIERI, RN, MSN, NP-C
STEPHANIE SMILEY, MSHS, PA-C
JENNIFER KOZAK, RN, MSN, FNP-C
COKA YIP, RN, MSN, FNP-C

28963 LITTLE MACK, SUITE #101
ST. CLAIR SHORES, MICHIGAN 48081

OFFICE: 586-447-0700
FAX: 586-447-0795
ANSWERING SERVICE: 586-693-3876

ATTENTION ALL PATIENTS

Every day new insurance companies are forming and present companies are changing. Consequently, it is impossible for us to know exactly what your insurance company will cover.

Please check with your insurance carrier so you will be aware of your coverage regarding office visits, x-rays, blood tests, emergency visits, surgeries, etc. It is to your benefit to be well informed to prevent having to pay for a service that may have been covered if you had a referral, prior authorization, second opinion, etc.

- If you do not inform us of any insurance changes, you will be responsible for the services rendered.
- If your insurance plan does not cover services that are rendered, you will be responsible for those services.
- You are responsible for all co-pays and deductibles.
- If you have no insurance, you are totally responsible for all services rendered. Talk to us about payment plan arrangements.

I have read the above information and I understand it.

Patient's Signature (Parent/Guardian)

(Date)

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claims.

I hereby authorize G.I. Medicine Associates, P.C. to apply for benefits on my behalf for covered services rendered by them or by their order. I request the payment from my insurance company to be made directly to G.I. Medicine Associates, P.C. (or to the party who accepts assignment).

I permit a copy of this authorization to be used in place of the original.

I certify that the information that I have reported with regard to my insurance coverage is correct.

Patient's Signature (Parent/Guardian)

(Date)