



# Welcome To Our Office!

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
          First                    Middle                    Last

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (    ) \_\_\_\_\_ Cell: (    ) \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Email Address: \_\_\_\_\_

May we E-mail appointment reminders to this address?    Yes            No

May we E-mail your health information here?            Yes            No

May we contact you at work?                                Yes            No

Employer: \_\_\_\_\_ Years There: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Years There: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

May we discuss your health information with your spouse/significant other?    Yes            No





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Patient's Name: \_\_\_\_\_  
                                    First                                    Middle                                    Last

*[Primary Insurance]*

Insured's Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

*[Secondary Insurance]*

Insured's Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Any diagnostic testing (labs, blood work, pap smears, etc.) is billed separately and is not included in the physician's charges. This additional testing will likely result in a separate bill from a third party entity such as the lab or pathologist.

Co-payment is required at the time of the visit. There is a \$10 service fee if payment is not made at this time.

We understand that your time is valuable. Please consider the needs of other patients. If you are unable to keep your scheduled appointment please contact this office at least 24 hours before your scheduled appointment so that we may improve access for other patients. If you fail to provide a 24 hour notice your account may be assessed with a \$25 No Show fee payable/due before your next visit.

This office will gladly complete any paperwork needed for FMLA, disability, and/or work. There will be a \$10 charge upon receiving your necessary paperwork.



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Patient's Name: \_\_\_\_\_  
                                    First                                    Middle                                    Last

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. Additionally, please be reminded that you agree to notify us of any change in insurance before any services are provided. We will not be responsible for any denied claims due to filing deadlines if new insurance was not given at the time of service.

Billing statements are sent out at the beginning of each month. Any balance not covered by your insurance must be paid in full before your next appointment. Unpaid balances over 90 days may be turned over to collections, and additional fees may be assessed.

Signature of Patient or Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

I authorize the release of any medical information necessary to process my claim.  Signed: _____ (Patient or responsible party)  Date: _____
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I authorize payment of medical and surgical benefits to Round Rock OBGYN.  Signed: _____ (Patient or responsible party)  Date: _____
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## Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use of disclosure of my health information:

\_\_\_\_\_ Accept      \_\_\_\_\_ Denied

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Print Name

Date: \_\_\_\_\_