



Welcome To Our Office!

Name: _____ Date: _____
First Middle Last

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone: () _____ Mobile phone: () _____

Birth date: _____ Age: _____ SSN: _____

Email Address: _____

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

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

Employer: _____

Occupation: _____ Work Phone: () _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Name of Spouse: _____ Date of birth: _____

SSN: _____ Employer: _____

Occupation: _____ Work Phone: () _____

Spouse Employer's Address: _____

City: _____ State: _____ Zip: _____



Welcome To Our Office!

Patient's Name: _____
First Middle Last

Our office will file for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, co-pays, 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 information 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.

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

Diagnostic testing (labs, blood work, pap smears, biopsies, mammograms, etc.) is billed separately and is not included in this office's charges. Additional testing will result in a separate bill from a third party entity such as the lab, radiologist, or pathologist. These charges are NOT controlled or managed by this office.

I authorize the release of any medical information necessary to process my claim. _____
Initial

I authorize payment of medical and surgical benefits to Round Rock OBGYN, PA. _____
Initial

By signing below I am stating that I understand the above office and billing policies.

Signature of Patient or Responsible Party: _____

Date: _____



Welcome To Our Office!

Patient's Name: _____
First Middle Last

General Patient Authorization

Consent to Treat

I hereby authorize Round Rock OBGYN, PA, a professional association, to render care to me during my office visits and to fulfill the orders of my physicians, including consultants, associates, and assistants of the physicians' choice.

Financial Authorization

I understand that I am financially responsible for services provided which are to be paid on the day services are rendered. I understand that Round Rock OBGYN, PA may not be a participating physician in my commercial insurance plan, therefore I am responsible for the total charges for services rendered. I agree that all amounts are due upon request and are payable to Round Rock OBGYN, PA. I further agree that should this account become delinquent, I am responsible for reasonable attorney or collections expenses.

I understand that if I do not pay the entire new balance within 25 days of monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in Round Rock OBGYN, PA being unable to continue providing medical services.

Consent to Release Medical Information

I authorize Round Rock OBGYN, PA to release medical information pertaining to my diagnosis and/or treatment, laboratory results, medical history, treatment, or any other such related information to:

- My insurance company(ies) or its designated representatives
- Any person(s) or entities financially responsible for my care or treatment
- Representatives of local, state, or federal agencies in accordance with law
- Employees or representatives for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against Round Rock OBGYN, PA or the employees of Round Rock OBGYN, PA.

Signature of patient or legal representative

Date



Welcome To Our Office!

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
- 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 Round Rock OBGYN, PA reserves the right to change its notice and practices. 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 Round Rock OBGYN, PA 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: _____