

Hill Country OB/GYN Associates

I. PATIENT INFORMATION

Name: _____
Address: _____
City, State: _____ Zip Code: _____
Phone: _____ () Home () Work () Other
Phone: _____ () Home () Work () Mobile () Other
Phone: _____ () Home () Work () Mobile () Other
Email Address: _____
Date of Birth: _____ Age: _____
Social Security #: _____
() Single () Married () Divorced Race: _____

() Employed () Unemployed () Retired () Student
Employer: _____
Employer Address: _____
Occupation: _____
How were you referred to our practice?
() Physician () Patient () Phone Book () Other: please describe
Name? _____
May we send a thank you card for your referral? () Yes () No
Who is your PCP? _____
How would you like to be contacted?(Check all that apply.)
 Home Ok to leave message Y / N (Circle one)
 Work Ok to leave message Y / N (Circle one)
 Written Communication Please mail to: HM / WK
 Email

II. AUTHORIZATION TO RELEASE INFORMATION

I authorize Hill Country OB/GYN Associates and its designated representatives to release medical information to the following:

Signature _____ Date _____

III. RESPONSIBLE PARTY (to be filled out if patient is under 18)

() Same As Patient - If the same please move on to next section
() Parent () Guardian () Spouse
Name: _____
Address: _____
City, State: _____ Zip Code: _____
Phone: _____ () Home () Work () Other

PRIMARY POLICY HOLDER

() Same as Patient () Spouse () Guardian () Parent
Person with whom the policy is carried.
Name: _____
Relationship To Patient: _____
Social Security #: _____
Date Of Birth: _____

IV. MINOR CONSENT FOR TREATMENT - If this does not apply, please go to next section.

I authorize medical examination and treatment by Hill Country OB/GYN Associates for the patient above.
Signature _____ Date _____

V. Ada Madrina

Skin Concerns: (circle all that apply) Fine Lines/ Wrinkles Sun Damage Laugh Lines Redness Acne Dry Skin Oily Skin
Please let us know if you are interested in a complimentary:
 Skin Consultation Before your appointment
 Glominerals Cosmetics makeover or color match After your appointment
May we add you to our mailing list? YES / NO Call me to set up an appointment
Email address: _____

VI. EMERGENCY CONTACT INFORMATION (Please list a different number than given above.)

Name: _____ Relationship: _____ Phone: _____

VII. BLOOD PRODUCTS - Would you consent to a blood transfusion in the event of a life threatening emergency during surgery or childbirth?
Please initial Yes _____ NO _____ If not please discuss this with your physician

VII. ASSIGNMENT AND RELEASE

I, the undersigned certify that I, or my dependent have insurance coverage with _____ assigned directly to Hill Country OB/GYN Associates all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
Responsible Party Signature _____ Relationship _____ Date _____

Hill Country OB/GYN Associates

Office Policy on Insurance & Appointment Cancellations

In order to accommodate the needs of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide service to you, it is very difficult to keep track of all the individual requirements. Even within the same insurance company, plans differ depending upon what type of contract your employer has negotiated. Providing quality medical care for our patients is our primary concern. **We highly recommend that you read your insurance booklet or contact your insurance company about your benefits.** Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, pre-existing, etc.

HMO/PPO/Managed Care Plans (i.e. Humana, United Health Care, BCBS)

If your doctor is a provider for your plan, we will file the claim for you. You are responsible for any co-payment or deductible. If your plan requires prior authorization to see a specialist, the patient is always responsible for getting the referral to our office before the day of the appointment. You will be billed for any non-authorized office visits.

Indemnity Insurance

On your first visit, payment is expected at the time of service. If we can verify that you have met your deductible, we will file to your insurance and collect your percentage.

Uninsured/Self Pay

Payment is expected at the time of service. If you are unable to pay in full, please contact our office prior to your visit to make payment arrangements.

Lab Work

All lab work will be billed separately by the respective laboratory, and is **not** included in the charges for this office. Any questions regarding bills for lab work should be addressed with the laboratory.

Appointments/Cancellations

Our policy is to charge for the 2nd missed appointment without a 24 hour notice at the rate of \$25.00. Please help us serve you better by keeping scheduled appointments. We realize your time is valuable and will do our best to see you at the time of your appointment. Please understand that medical emergencies and unexpected delays are a part of medical care.

Acknowledgement of Fee's

There will be a **\$25.00** fee for the first set of **FMLA/Disability forms** and **\$15.00** for each additional set of forms. Please allow **10** business days for completion of forms. Payment is due when forms are presented.

Medicaid

If at any time you enroll in Medicaid we are contracted **only** with **Traditional and Superior**.

I have read and understand the above information.

Patient or Responsible Party Signature

Relationship

Date

HIPPA Acknowledgement of Receipt

I, _____ acknowledge that **I have received Hill Country OB/GYN Associates Notice of Privacy Practices**. Please contact our Privacy Officer if you have concerns or questions regarding the Notice of Privacy Act policy.