Hill Country OB/GYN Associates

I. PATIENT INFORMATION

Name: ____________________

Address: ____________________

____

City, State: __________ Zip Code: __________

Phone: __________ ( ) Home ( ) Work ( ) Cell ( ) Other

Phone: __________ ( ) Home ( ) Work ( ) Cell ( ) Other

Email Address: ____________________

Date of Birth: __________ Age: ______

Social Security #: ____________________

( ) Single ( ) Married ( ) Divorced Race: ______

( ) Employed ( ) Unemployed ( ) Retired ( ) Student

Employer: ____________________

Employer Address: ____________________

____

Employer Phone # : ____________________

How were you referred to our practice?
( ) Physician ( ) Patient ( ) Phone Book ( ) Other
Name?

May we send a thank you card for your referral?

( ) Yes ( ) No

How would you like to be contacted? (Check all that apply)

☐ Home Ok to leave message Y / N (Cirle one)

☐ Work Ok to leave message Y / N (Cirle one)

☐ Written Communication Please mail to: HM / WK (Circle one)

II. AUTHORIZATION TO RELEASE INFORMATION

I authorize Hill Country OB/GYN Associates and its designated representatives to release medical information to the following person (s): ____________________ ____________________

Patient Signature: ____________________ Date

III. RESPONSIBLE PARTY (Person responsible for bill)

( ) 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

( ) Employed ( ) Self Employed ( ) Retired ( ) Student

Employer: ____________________

Phone # : ____________________

Date of Birth: ____________________

Social Security #: ____________________

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

I ___ **DO** ___ **DO NOT** authorize medical examination and treatment by Hill Country OB/GYN Associates for the patient above.

Signature ____________________ Date ____________________

V. PRIMARY INSURANCE INFORMATION - COMPLETE THIS SECTION.

Insured Name: ____________________

Insurance Company: ____________________

Address: ____________________

____

Relationship To Patient: ____________________

Social Security #: ____________________

Date Of Birth: ____________________

Insurance Phone: ____________________

Insured ID #: ____________________

Group #: ____________________

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 threating 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 please 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 are more than willing to provide care within your insurance guidelines if you let us know at the time of service what those guidelines are. **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 apart 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 7-10 business days for completion of forms. Payment is due when forms are presented.

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.