Round Rock OBGYN, PA
Patient Registration

Name: ____ Date: __________________
First Middle Last

Home Address: ____

City: ______________________________ State: _________ Zip: _______________________

Mobile phone: ( ) ___________________ Home phone: ( ) ___________________

Date of Birth: _______________ Age: _________ SSN: ____________________________

Email Address: ____

Employer: ___________________________

Occupation: ________________________________

Work Phone: ( ) _____________________

Employer's Address: ____

City: _________________________________ State: ____________ Zip: __________________

In case of **emergency**, contact: ____________________________ Relationship: ______________

Home Phone: ( ) ___________________ Work Phone: ( ) ___________________

How did you learn about our practice? ____

Who is your primary physician? : ____

May we send notes/medical records regarding your care to your primary doctor? Yes No

Revised 1/31/2013

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Name: ____ Date: ______________
First Middle Last

Spouse/Partner information

Spouse/partner name: __________________________ Date of birth: _________________

SSN: ____________________________

Employer: ________________________

Occupation: _______________________

Mobile phone: (   ) ________________ Work Phone: (   ) ________________

Spouse/Partner Employer's Address: ____

City: ____________________________ State: _______ Zip: ______________

There are times when we will need to communicate with you by telephone regarding appointments and/or your care.

The information may be confidential.

We will attempt to contact you using the information you have provided. If this is unacceptable, please notify this office in writing.

If you would like to grant access for us to discuss your personal health information with another individual, please list them below.

Name:_____________________ DOB:____________ Relationship:______________

Name:_____________________ DOB:____________ Relationship:______________

I understand all precautions will be taken to protect my privacy. I will notify this office in writing of any changes to this document or the associated permissions.

Signature: ________________________________ Date: ______________

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Name: ____ Date: _______________
First Middle Last

Primary Insurance:
Name of Insurance Company: ____

Phone number for Insurance Company: __________________________________

Insured's Name: _________________________ Relationship: ________________

DOB: ____________________ SSN: ________________

Secondary Insurance:
Name of Insurance Company: ____

Phone number for Insurance Company: __________________________________

Insured's Name: _________________________ Relationship: ________________

DOB: ____________________ SSN: ________________

Complete this section ONLY if someone other than the patient or spouse is financially responsible.

Responsible Party: ____________________________ Relationship to Patient: _______

Home Address: ____

City: __________________________ State: _________ Zip: __________

Telephone: (   ) _______________ Mobile: (   ) ____________________

Birth date: ___________________ SSN: ________________

Employer: ___________________________________ Years There: __________

Occupation: _____________________________ Work Phone: (   ) ________________

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Name: ____
First Middle Last

Please read, initial and sign below

_____ **FINANCIAL RESPONSIBILTY:** I understand that I am ultimately responsible for payment on my account. Payment is expected at the time of service. I understand that I am responsible for any referral or authorizations that my insurance may require and for any charges not covered by my insurance plan, including co-payments, co-insurances and deductibles. Claims will be filed for PPO and HMO participants. Payment of benefits will be made directly to Round Rock OBGYN. *I understand and accept that by paying with a check, I expressly authorize Round Rock OBGYN to electronically debit my checking account for the amount of the check. If my check is dishonored or returned for any reason I understand that I will be responsible for a $30 returned check charge. I also understand that if I do not pay all of the charges due from me and my past due account is sent to an outside collection agency, an additional fee equal to the collection agency's commission will be added to my outstanding balance.*

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

_____ **INSURANCE COVERAGE:** I understand that I am responsible for providing my physician with any and all insurance coverage at each and every visit. I will be responsible for any balances due as a result of not disclosing this information.

_____ **LABORATORY FEES:** Diagnostic testing (labs, blood work, pap smears, biopsies, mammograms, etc.) is billed separately and is NOT included in this office's charges. Additional testing may 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 understand my physician uses Clinical Pathology Laboratories (CPL). Round Rock OBGYN cannot guarantee my insurance will cover any labs/pathology performed at or ordered by my physician. If my insurance requires use of a different lab, I understand it is my responsibility to inform my physician for proper handling.

_____ **FEE FOR 'NO SHOW':** I understand that a $25 'no show' fee will be assessed for appointments that I do not keep. (First missed appointment will be waived.)

_____ **FEE FOR FORMS COMPLETION:** 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.

_____**HIPPA:** I acknowledge that I have received or have access to a copy of Round Rock OBGYN, PA's Notice of Privacy Practices.

_____**Multiple missed appointments, multiple cancellations, or failure to comply with the recommended studies, follow-up, or treatment plans may result in dismissal from this practice at the sole discretion of the physician(s).**

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

Signature: ____ Date: ___________________

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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 with my commercial insurance plan; I understand 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.

Consent to Release Medical Information

I authorize Round Rock OBGYN, PA to release my medical information related to my diagnosis, care, and/or treatment, including all laboratory results, studies, imaging, 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 the 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.
- I hereby authorize my physician (Round Rock OBGYN, PA) to release all of my medical information and records to hospitals/medical facilities/clinics/physicians for the purpose of care/treatment, consultation, referral, surgery/procedure(s), pregnancy, or emergency care.
- I authorize the release of any medical records or other information necessary to process my insurance claim.

____ ____________________

Signature of patient or legal representative Date

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