Balcones Obstetrics & Gynecology, PA
3705 Medical Parkway, Ste 540
Austin, Texas 78705

PATIENTS NAME: _____
LAST FIRST M

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL:** _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____/_____/_____

MARITAL STATUS: S, M, D, W **DRIVER'S LICENSE #:** _____

EMPLOYER: _____ **OCCUPATION:**_____

EMERGENCY CONTACT: _____ **CONTACT #** _____

PRIMARY INSURANCE ***PLEASE COMPLETE THIS SECTION AND PRESENT YOUR CARD TO THE FRONT DESK. THANK YOU***

INSURANCE COMPANY: _____ **PHONE #:** _____

POLICY #: _____ **GROUP #:** _____

POLICY HOLDER'S NAME: _____ **DATE OF BIRTH:** _____

POLICY HOLDER'S SS#: _____ **RELATIONSHIP TO PATIENT:** _____

SECONDARY INSURANCE
INSURANCE COMPANY: _____ **PHONE #:** _____

POLICY #: _____ **GROUP #:** _____

POLICY HOLDER'S NAME: _____ **DATE OF BIRTH:** _____

POLICY HOLDER'S SS#: _____ **RELATIONSHIP TO PATIENT:** _____

REASON FOR APPOINTMENT: _____

OTHER CONDITIONS/COMPLICATIONS: _____

_____

I acknowledge that I have been read, understand and been offered a copy of the HIPAA policies of Balcones Obstetrics & Gynecology, PA.

I authorize qualified staff to perform upon me, rehabilitation, therapy and/or any other care including treatment necessary to improve my well being. I acknowledge that no guarantees can be made to me as to the outcome of treatment.

I authorize my insurance benefits to be paid directly to Balcones Obstetrics & Gynecology, PA realizing I am responsible to pay non-covered and/or denied services. In the event that my insurance carrier denies payment for any reason, I acknowledge that I am responsible for payment of services provided to me.

I authorize the release of information to my insurance carrier named above concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to my referring physician and any physician I am recommended to see for continuation of care. I understand that the release of information will only consist of medical records belonging to Balcones Obstetrics & Gynecology, PA.

PATIENT SIGNATURE: _____ **DATE:** _____