Obstetrics & Gynecology of North Texas

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Please complete the following: (please print neatly)* **Date: _____**

Patient's Name:		Marital Status:	
Patient's Date of Birth:		Occupation:	
Social Security:		Employer/School Name:	
Current Address:		Address:	
City/State/Zip Code:		City/State/Zip:	
Primary Phone:		Pharmacy Name:	
Secondary Phone:		Address or Cross Street:	
Email:		Pharmacy Phone:	
***Preferred Communication** *(for appointment reminders): Phone – Email – Text*		**Primary Care Physician:**	

Insurance Policy Holder's Information *(if patient is policy holder, please skip this section)*

Name:		Relationship to Patient:	
Date of Birth:		Marital Status:	
Primary Phone:		Social Security:	
Email:		Employer/School Name:	
Current Address:		Address:	
City/State/Zip:		City/State/Zip:	
Emergency Contact Information			
Name:		Relationship:	
Primary Phone:		Secondary Phone:	
Address:		City/State/Zip:	

FINANCIAL POLICY, AUTHORIZATION FOR TREATMENT AND ASSIGNMENT

**Our office files all charges for Managed Care Contracts in which we are participants. We file on indemnity plans only for hospital inpatient and outpatient fees. Your portion will be determined by your insurance plan and our office will convey that information to you. The estimated amount of non-insurance reimbursement will be required as a deposit in non-emergency cases. For obstetrical care, this estimated amount will be collected prior to your 32nd week of pregnancy. Additional billing or refund may occur after insurance reimbursement is received.

**I authorize treatment and agree to pay all fees and charges for such treatment. I agree to pay all charges incurred by me and/or members of my family upon presentation of the statement for same, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date.

**I hereby assign to the above physicians all proceeds from my insurance carriers for services provided. I authorize release of all medical records required by my insurance carriers to obtain payment for services received. This authorization shall remain in effect until revoked by me in writing. (A copy of this assignment is valid as the original).

**Your portion of payment for all office services is due at the time of service. We accept VISA, MasterCard, American Express, Discover, CareCredit, cash, or check. All benefit quotes or prices given are only an estimate and are subject to change based on your insurance carrier determination You may have and additional balance due.

**I understand there will be a twenty-five dollar ($25.00) charge for all non-emergency after hours phone calls. This is not reimbursable by insurance.

NOTICE: Do not sign this agreement before you read.

Patient Name: _____ Signature of Patient/Legal Guardian: _____ Date: _____