Southeast Texas OB/GYN Associates, P.A.

755 N. 11th Street, Suite P4200 • Beaumont, Texas 77702 • (409) 899-1499

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SS#: _____

Appointment Date:_____ DOB: _____

PLEASE PRINT, SIGN AND DATE THIS CONSENT/ASSIGNMENT Age: _____

Patient Information: Preferred Pharmacy:_____ Referring Physician:_____

Name:_____ Preferred Name:_____Marital Status _____
Last First Middle Maiden

Address:_____City, State, Zip_____

Home Phone:(____)_____ Cell Phone (____)_____ Email Address _____

Employer:_____Employer Phone(____) _____

Employer Address:_____City, State, Zip_____

Spouse's Name:_____Spouse's Date of Birth _____

Spouse's Employer:_____Address _____

City, St., Zip:_____ Spouse's Employer Phone (____) _____

PRIMARY INSURANCE

NAME INSURANCE CO #1_____POLICY #_____GROUP # _____

INSURED NAME_____INSURED DOB _____

Address_____City, State, Zip _____

Phone(____)_____Relation to Patient_____INSURED S.S.# _____

INSURED Employer_____Employer Address_____

SECONDARY INSURANCE

NAME INSURANCE CO #2_____POLICY #_____GROUP # _____

INSURED NAME (if different)_____RESPONSIBLE PART'S DOB _____

Address (if different)_____City, State, Zip_____

Phone(____)_____Relation to Patient_____S.S.# _____

Employer_____Employer Address _____

Emergency Notification

Name:_____ Relationship:_____

Cell Phone:(____)_____ Work Phone (____)_____

Assignment of Benefits/Consent for Treatment

I hereby agree to pay in full for medical services unless otherwise contractually or statutorily prohibited. I understand that I will be financially responsible for any charges not paid by my insurer, employer, or other third party. I also agree that any payment due from me will be made at the time services are rendered or promptly upon billing. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result or outcome of treatments, examinations, or testing by SETX OB/GYN.

I authorize and request payments of medical benefits directly to SETX OB/GYN. I further authorize SETX OB/GYN to release to my insurance company(s) any and all medical information (including that of confidential nature) necessary to process my insurance claims, and to any healthcare provider for continuation of my healthcare.

Sign:_____ Date:_____

NEW PATIENT
GYN HISTORY

OFFICE USE ONLY
WT.
BP.
HGT.

In order to give you more complete medical care, we recommend an annual physical examination and certain appropriate laboratory studies.

Please answer as directly and briefly as possible the following medical history:

Pharmacy:_____

1) NAME:_____ **AGE:**_____ **DATE:**_____

MARITAL STATUS: S M D W Separated_____ **DATE OF BIRTH:** _____

OCCUPATION: _____ **INSURANCE:** _____

PRESENT PROBLEMS: _____ **HOW LONG?** _____

1. _____

2. _____

3. _____

PERSONAL HISTORY

Weight _____ **Now** _____ **1 year ago** _____ **Highest** _____ **When** _____

2) HAVE YOU EVER HAD:

	No	Yes
German measles	❑	❑
Mumps	❑	❑
Chicken pox	❑	❑
Scarlet fever	❑	❑
Diphtheria	❑	❑
Pneumonia	❑	❑
Rheumatic fever	❑	❑
Heart disease	❑	❑
Heart murmur	❑	❑
Polio or meningitis	❑	❑
Kidney infections	❑	❑
Gonorrhea or syphilis	❑	❑
Anemia	❑	❑
Jaundice	❑	❑
Gallbladder disease	❑	❑
Epilepsy	❑	❑
Migraine headaches	❑	❑
Tuberculosis	❑	❑
Phlebitis	❑	❑
Cancer	❑	❑
High or low blood pressure	❑	❑
Nervous breakdown	❑	❑

3) DO YOU NOW HAVE OR HAVE YOU EVER HAD:

	No	Yes
Any eye disease, injury, impaired sight	❑	❑
Any ear disease, injury, impaired hearing	❑	❑
Any trouble with nose, sinuses, mouth, throat	❑	❑
Any head injury, fainting spells, convulsions	❑	❑
Frequent or severe headaches	❑	❑
Skin disease	❑	❑
Chronic or frequent cough	❑	❑
Chest pain, or spitting up of blood	❑	❑
Night sweats	❑	❑
Shortness of breath	❑	❑
Swelling of hands, feet or ankles	❑	❑
Varicose veins	❑	❑
Kidney or bladder disease	❑	❑
Indigestion, stomach trouble or ulcer	❑	❑
Rectal bleeding, constipation or diarrhea	❑	❑
Loss of urine with cough or sneeze	❑	❑
Thyroid trouble	❑	❑
Test for "sugar" diabetes	❑	❑
Any female hormones	❑	❑

Broken bones: _____ _____ _____

Accidents: _____ _____ _____

Surgery - what, when, where –

_____

_____

_____

Hospitalizations - what, when, where –

_____

_____

MAMMOGRAM: Y N DATE: PLACE: _____

4) Social History:

Alcoholic Beverages ❑ **Never** ❑ **Moderate** ❑ **Daily** **Cigarettes** _____**packs per day.**

5) MENSTRUAL HISTORY:

Age at onset_____ Regular: ❑ No ❑ Yes Cycle:_____Days (from start to start) Usual duration: _____ Days

Flow: ❑ Light ❑ Mod ❑ Heavy Pains or Cramps ❑ No ❑ Yes Date of last period _____

Painful intercourse? ❑ No ❑ Yes Bleeding after intercourse? ❑ No ❑ Yes Date of last Pap Test:_____

Vaginal discharge: ❑ No ❑ Yes _____

6) Birth Control Methods: _____

Sexual problems No ❑ Yes ❑ _____

7) LIST PREGNANCIES (INCLUDE MISCARRIAGES)

YEAR	BIRTH WEIGHT	SEX	HOURS OF LABOR	ANESTHESIA	COMPLICATIONS

Number of adopted children: _____

8)

Family History	Living Age	Living Health	Deceased Age	Deceased Cause
Father				
Mother				
Brother or Sister 1				
2				
3				
4				
5				
Husband				
Son or Daughter 1				
2				
3				
4				
5				

Has any relative ever had:	NO	YES	WHO
Cancer	❑	❑	
Tuberculosis	❑	❑	
Diabetes	❑	❑	
Heart Trouble	❑	❑	
High Blood Pressure	❑	❑	
Stroke	❑	❑	
Epilepsy	❑	❑	
Suicide	❑	❑	
Mental Illness	❑	❑	
Hysterectomy	❑	❑	
Cesarean Section	❑	❑	
Kidney Trouble	❑	❑	
Birth Defects	❑	❑	

9) IMMUNIZATIONS:

Primary Date	Booster
RUBELLA / GERMAN MEASLES / 3 DAY MEASLES	

Transfusions No ❑ Yes ❑ How many_____ Blood type:_____

What medicines are you now on and dose: 1. _____

2. _____ 3 _____

Allergies to medicines:_____

_____

Have you had x-rays in the last year? _____

Have you seen a physician in the last year? No ❑ Yes ❑ Name of physician: _____

Reason for seeing physician _____

_____

_____

10) Comments/Suggestions toward improvement of your care: _____

_____

_____

_____

 Reviewed by_____

SOUTHEAST TEXAS OB/GYN ASSOCIATES, P.A.
FINANCIAL POLICY

Southeast Texas OB/GYN Associates, P.A. believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. All past due balances are due at time of check-in unless previous arrangements have been made with our business office.

INSURANCE is a contract between you, your employer and the insurance company. **We are not a party to that contract**. It is very important that you understand the provisions of your policy. It is your responsibility to verify that we are an in-network provider on your specific plan. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide ***accurate*** and ***timely*** insurance information. Therefore, we ask you to ***bring your current insurance card and driver's license to each visit***. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company will result in the guarantor being responsible for payment.

If you have insurance coverage under a plan with which we do not have a contract, or if you are un-insured, you will be required to pay ***in full*** at the time of service for all office visits and/or procedures. You may be given a same-day discount for most services when full payment is received. Some exclusions may apply due to cost of medications, etc.

The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor as well as the payment in full for services provided.

Initial:_____

BILLING: Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. You should call your insurance company for any questions regarding how they processed your claim(s). You may call the billing office for any other questions regarding your bill or to discuss payment options.

Effective January 1, 2013: If payment arrangements are necessary, they must be made immediately with our billing office. An initial payment of at least ***25% of the full balance owed*** will be required. Any account balance outstanding longer than ***90 days*** will be charged a ***$15 per month*** billing fee and may be forwarded to a collection agency. In the event an account is placed with an agency for collection purposes, the patient will be responsible for all collection agency fees (up to 35% of the balance placed for collection). In addition, the patient will be responsible for all court costs, filing fees and attorney fees should this account require litigation.

Patients with a delinquent account must be paid in full prior to receiving services from our staff or physicians.

RETURNED CHECKS: A $30.00 fee will be charged for any checks returned for insufficient funds. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge.

Initial:_____

FORM FEES: Completing disability insurance forms and employer forms is not a medical service and is not paid by insurance. It requires office staff time and time away from patient care for our doctors. However, we provide a complementary service of preparation of one set of forms for our patients. We require pre-payment of $15 for each additional form. Please provide at least 2 weeks notice or lead time for completion.

We welcome the opportunity to discuss any aspect of our financial policy. If you have any questions, please contact our Business Office at (409) 899-1499 ext. 6188.

I have read and understand the above financial policy of Southeast Texas OB/GYN Associates, P.A. and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time without prior notification to the guarantor.

_____ _____ _____

Patient Signature Printed Name Date

Consent for Release of Protected Medical & Billing Information

_____ I will allow ALL results including ABNORMAL results to be released to the following:

_____ _____
Name Relation

_____ _____
Name Relation

_____I will allow INSURANCE AND BILLING or information to be discussed regarding my ACCOUNT with the following:

_____ _____
Name Relation

_____ _____
Name Relation

_____I will allow SCHEDULING APPTMNTS to be discussed with the following:

_____ _____
Name Relation

_____ _____
Name Relation

_____May leave message on: (circle one or both) answering mach (home) voice mail (cell)

_____I do <u>NOT</u> want <u>ANY</u> test results released to anyone but <u>MYSELF</u>.

_____
Printed name of patient

_____
Signature of patient

_____
Date

******This consent will expire one year from date above**