AUSTIN AREA OBSTETRICS
GYNECOLOGY & FERTILITY

PATIENT AUTHORIZATION FORM
Please read, initial, and sign below

(Initial)_____FINANCIAL RESPONSIBILITY: 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 authorization that my insurance may require and for any charges not covered by my insurance plan, including co-payments, co-insurance and deductibles. Claims will be filed for PPO and HMO participants, Medicare and Medicaid. Payment of benefits will be made directly to Austin Area OB/GYN.
I also understand that if I fail to pay amounts due my past due account will be sent to an outside collection agency.

(Initial)_____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. I understand that Austin Area OBGYN does not retro file for any Medicaid and Medicaid Managed Care plan. Austin Area OBGYN will only file for Medicaid and Managed Care Medicaid starting from the date the coverage is presented in the office for any future visits during that effective period.

(Initial)_____LABORATORY FEES: I understand that my physician uses Clinical Pathology Laboratory (CPL). Austin Area OB/GYN cannot guarantee my insurance will cover any lab/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.

(Initial) I DO_____ I DO NOT_____ CONSENT to necessary examinations and/or treatments performed and prescribed by my physician, nurse practitioner or physician's assistant as is necessary in his/her judgment, with patient approval. **Separate consent forms will be signed for procedures performed in the physician's office.**

(Initial)_____RELEASE OF INFORMATION: I do hereby authorize my physician to release information to the hospital facility in the event of a scheduled surgery or procedure, emergency care or pregnancy. I authorize the release of any medical records or other information necessary to process my insurance claim.

(Initial)_____GYN CASH PAY PATIENTS: I understand that if I am or were to become a Gyn cash pay patient, I am required to pay a deposit upon check in of my appointment. The cost will be $300 for new patients and $200 for established patients. I understand that any balance remaining will be due upon check out.

(Initial)_____OB CASH PAY PATIENTS: I understand that if I am or were to become an OB cash pay patient, I am required to pay a deposit upon check in of my appointment. The cost will be $500. I understand that any balance remaining will be due upon check out.

(Initial)_____HIPAA: I acknowledge that I have received or have access to a copy of Austin Area OB/GYN's Notice of Privacy Practices.

(Initial)_____: I authorize Austin Area OB/GYN to obtain my medication history from my pharmacy.

(Initial)_____: I understand that amounts collected are an estimate of my charges and that additional charges may be incurred.

(Initial)_____FEE FOR FORMS COMPLETION: I understand that I will be responsible for paying $25 for forms completed by my physicians or staff. (Example: Disability forms, FMLA forms, etc.) This does not include medical records which will be a separate fee outlined on the medical records release.

Emergency Contact: _____ Emergency Phone:_____

Your signature: _____ **Today's date:**_____
Revised 03/2017