Southeast Texas OB/GYN Associates, P.A.

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Bobbi Holder, RNC, WHNP
Lora Verrill, RN, NP-C

SS#: _____

Appointment Date:_____ DOB: _____

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

Patient Information: 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:_____