# Maternal Fetal Medicine Associates of South Texas, LLP


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## Patient Information

Name: ______________________________________________ Date of Birth: _________________ Age: _____

SS#: ______________________ Marital Status: ___________ Spouse/Partner Name: _______________________

Driver's License #: ____________________________ Referring Dr.: ___________________________________

Address: ____________________________ City: ___________________________ Zip Code: _____________

Home Phone#: _______________________ Cell#: ________________________ Work #:__________________

Occupation: _________________________________ Employer:_____________________________________

Employer Address: ____________________________City: ______________________ Zip Code: ____________

## Insured Information

Name: ______________________________________________ Date of Birth: _________________________

SS#: ______________________ Relationship to Patient:_____________________________________________

Address: ____________________________ City: ___________________________ Zip Code: _____________

Home Phone#: _______________________ Cell#: ________________________ Work #:__________________

Employer: _________________________________________________________________________________

Employer Address: ____________________________City: ______________________ Zip Code: ____________

Insurance Carrier: _________________________________________________________________________

Insurance ID #: ______________________________________________ Group#: _______________________

**AUTHORIZATION FOR CARE, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION**

I the undersigned, by presenting for services request and authorize evaluation, diagnosis and treatment by my physician and /or his designee. I further hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claims.

I acknowledge and understand that I am responsible for all the services rendered to me or any member of my family.

Signed: _______________________________________________ Date: ______________________________

I/we authorize direct payment to be made for any and all medical or surgical services rendered. I understand that if any services or charges are not covered by my insurance carrier or my eligibility cannot be verified, **I AM RESPONSIBLE FOR ALL CHARGES INCURRED**.

____________________________________ Printed Name: _______________________ Date:_____________

**Signature of Patient or Guardian**

**WE DO NOT FILE SECONDARY INSURANCE**

*Accredited by the American Institute of Ultrasound in Medicine*
*Certified by Fetal Medicine Foundation*