Maternal Fetal Medicine Associates of South Texas, LLP

210 Genesis, Suite A ♦ Webster, Texas 77598

Office Phone: (281) 338-7693 Fax: (281) 338-8849

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

Patient Name: _____ DOB: _____ /_____ /_____

I understand as part of my healthcare, Maternal Fetal Medicine Associates of South Texas, LLP., originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:
A basis for planning my care and treatment.
A means of communication among the many healthcare professionals who contribute to my care.
A source of information for applying my diagnosis and surgical information to my bill.
A means by which a third party payer can verify that services billed were actually provided.
A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
To object to the use of my health information for directory purposes.
To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested.
To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____
_____
_____

Patient:

_____ Date: _____

Signature of Patient or Legal Representative of Date Witness Signature
Consent to Use and Disclosure of Protected Health
Information for Treatment, Payment or Healthcare
Operations

_____

For Office Use Only

Accepted: _____ Date: _____

Denied: _____ Date: _____

Patient Information

If you are a new patient, please print and fill out the forms below in advance to your appointment.

Please bring the completed forms with you to your appointment along with a photo id and your current insurance card.

- Patient Information Form
- Ultrasound Limitation Acknowledgement Form
- HIPPA Form
- Family History Questionnaire Form

Patient Insurance and Payments

Please note all patient balances, copay, deductible and co-insurance are due at the time of services. A collection of payment is not a guarantee of coverage from your insurance provider. We do our very best to verify your insurance coverage before your visits; *however* verification is never a guarantee of coverage until your claim has processed through your insurance company. Insurance referral/authorizations must be approved for the day of your appointment or you will be considered self-pay.

Medicaid patients:

The law requires us to file any primary insurance you have on file along with your Medicaid. If you fail to provide your primary insurance and Medicaid denies your claim you will be responsible for any services rendered.

*Please note if you are **applying for Medicaid** let us know so we can request authorization for your services. If you fail to notify us before your appointment we **CANNOT/WILL NOT** file your insurance claim.*

***Please remember to bring a current photo identification card, insurance card, and any insurance authorization/referral for each visit. ***