Maternal Fetal Medicine Associates of South Texas, LLP

210 Genesis, Suite A ♦ Webster, Texas 77598

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

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