Jose E. San Martin MD
Obstetrics and Gynecology
25329 I-45 Suite 129
The Woodlands, Texas 77380
281-651-2090 office281-476-6611 Fax

San Martin OB/GYN and Women's Healthcare

PLEASE FILL INALL BLANKS AND BRING TO YOUR APPOINTMENT WITH INSURANCE CARD:

Name:_____ Date :_____
(Please print) Last First MI Home Phone:_( )_____
Address:_____ Cell#:_____
City:_____State:_____Zip:_____ Work#:_____
Employed: Yes ( ) No ( ) Student: Full time ( ) Part time ( ) Email Address:_____
Employer/School:_____ Date of Birth:_____
Employer Address: _____ SS#:_____
City:_____State:_____Zip:_____ Driver's License:_____
Occupation:_____ Martial Status: M( ) S( ) W( ) D( ) Sep( )

Billing Address if Different from Above:_____
Address City State Zip

PATIENT'S INSURANCE INFORMATION:

Is your insurance through your employer? Yes ( ) No ( ) Employer Name:_____
Your Insurance Company's Name_____ Insured's Name:_____
Relationship to Insured:_____
Group/Policy#_____ Insured SS# and Date of Birth_____

AUTHORIZATION FOR SAN MARTIN OB/GYN TO FILE YOUR INSURANCE

I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of government or medical benefits Sam Martin OB/GYN. *Patient's Signature* ⊗_____Date:_____

HOW DID YOU HEAR ABOUT US?

Friend ( ), Relative ( ), Dr. Referral ( )Ad ( )/*Other:*_____

HIPAA PRIVACY STATEMENT

All patients have the right to have confidential care provided. All information, medical or social, whether written, spoken, electronic, or computer generated, is to held in strict confidence (please refer to the San Martin OB/BYN Compliance Privacy Rules Notice).

If your lab testing is normal, our office may send you a private card notice. If anything is abnormal, our office will notify you by telephone. If you are not notified by phone or mail, please do not assume everything is normal. Call our office if it has been over two weeks since your test.

PATIENT RECORD OF DISCLOSURE

( )Yes ( ) No -May we speak to emergency contact about medical info if you are unable to be reached timely?

PATIENTS CONSENT #'S EMERGENCY CONTACT (other than Hm# or Wk#)

Home#: _____ Cell#: _____ Name: _____

Work#: _____ Other: _____ Phone#: _____

WE RESERVE THE RIGHT TO RELEASE MEDICAL INFORMATION IN EMERGENCY SITUATIONS

Your signature below only acknowledges that you have received the above HIPAA Privacy Notice regarding your rights to confidential care:

Signature of Patient or Guardian ⊗_____Date:_____

(__) Signature declined. The practice made a good faith effort to obtain the patient's written ackowledgement of the HIPAA Privacy Notice.

Year: 2012

FOR STAFF USE ONLY: Date: _____ Initials: _____

PATIENT'S FINANCIAL POLICY & BILL OF RIGHTS

1. I will make my every effort to understand the benefits of my insurance plan, even to the extent of calling the benefits coordinator at my place of employment/carrier.
2. I will cooperate with this medical practice to assure prompt payment for all services, including being responsible for any non-covered services.
3. I agree to pay a $35 charge for any check that is returned by my bank for any reason.
4. If I receive maternity services, I agree to discuss any change of insurance plan with the *San Martin OB/GYN's* business office before making the change. Failure may result in denial of payment, which makes the patient responsible.
5. I agree that this office can bill only for a diagnosis documented in my medical record. Thus, to ask you to change a diagnosis for the purpose of securing payment from my insurance carrier may result in an act of fraud.

INITIAL/DATE *** *I understand San Martin OB/GYN will only file Medicaid/Texas Health Network for services incurred once verification of coverage is obtained. Temporary ID cards, or verbal authorization is not acceptable. Once coverage is verified, San Martin OB/GYN will file only from that day forward and for no dates prior to this verification. Any monies due to San Martin OB/GYN for services prior to the verification date are my responsibility.*

Please sign that you have read and understand the *Financial Policy/Patient Bill of Rights & HIPAA Privacy Statement.*

Date:

Any charges or fees quoted to you by employees or physician at San Martin OB/GYN are based on information quoted to us by your insurance company. The insurance company, however, stresses that it is not a guarantee and that the correct amount due by the patient cannot be completely determined until after the claim is processed. Therefore, you may owe additional charges after we receive payment by the insurance company, for which you will receive a bill. We regret any inconvenience this will cause.

PATIENT CONSENT FORM
FOR MEDICAL AND/OR SURGICAL TREATMENT

I authorize the physician at *San Martin OB/GYN* to provide medical care, including without limitations, routine diagnostic procedures and medical treatment, which includes any procedures deemed necessary by the attending physician or other such physicians or assistants as may be designated by the physician for medical care.

I understand no warranty, guarantee or assurance has been made by *San Martin OB/GYN* as to the results of any treatment, examinations, or other medical care.

Date

Patient's Signature

Witness

If Patient is a Minor, Parent or Legal Guardian must also sign

Date

Patient's Signature

Witness

NOTICE CONCERNING COMPLAINTS

Complaints about your physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners. including physician assistants and acupuncturists, may be reported for investigation at the following address: Texas State Board of Medical Examiners Attention: 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263 Austin, Texas 78768-2018