Balcones Gynecology
3705 Medical Parkway, Ste 540
Austin, Texas 78705

PATIENTS NAME: ____
LAST FIRST M
ADDRESS: ____

CITY: ________________________________ STATE: ______________________ ZIP: _____________

PRIMARY PHONE: _______________________ SECONDARY PHONE: ___________________

SOCIAL SECURITY #: ___________________________ DATE OF BIRTH: ______/_______/______

MARITAL STATUS: S, M, D, W DRIVER'S LICENSE #: _______________________________

EMPLOYER: ______________________________ OCCUPATION:_____________________________

EMERGENCY CONTACT: ___________________________ CONTACT # _______________________

EMAIL ADDRESS: ____

PRIMARY INSURANCE ***PLEASE COMPLETE THIS SECTION AND PRESENT YOUR CARD TO THE FRONT DESK ***

INSURANCE COMPANY: ____ PHONE #: _________________________________

POLICY #: ____ GROUP #: ________________________________

POLICY HOLDER'S NAME: ____ DATE OF BIRTH: ______________________

POLICY HOLDER'S SS#: __________________________________ RELATIONSHIP TO PATIENT: ____________________

SECONDARY INSURANCE
INSURANCE COMPANY: ____ PHONE #: _________________________________

POLICY #: ____ GROUP #: ________________________________

POLICY HOLDER'S NAME: ____ DATE OF BIRTH: ______________________

POLICY HOLDER'S SS#: __________________________________ RELATIONSHIP TO PATIENT: ____________________

I acknowledge that I have been read, understand and been offered a copy of the HIPAA policies of Balcones Gynecology.

I authorize qualified staff to perform upon me, rehabilitation, therapy and/or any other care including treatment necessary to improve my well being. I acknowledge that no guarantees can be made to me as to the outcome of treatment.

I authorize my insurance benefits to be paid directly to Balcones Obstetrics & Gynecology, PA realizing I am responsible to pay non-covered and/or denied services. In the event that my insurance carrier denies payment for any reason, I acknowledge that I am responsible for payment of services provided to me.

I authorize the release of information to my insurance carrier named above concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to my referring physician and any physician I am recommended to see for continuation of care. I understand that the release of information will only consist of medical records belonging to Balcones Obstetrics & Gynecology, PA.

PATIENT SIGNATURE: ____ DATE: ________________________