CENTRAL TEXAS OB/GYN ASSOCIATES PATIENT AUTHORIZATION FORM

Please read, initial, and sign below

(Initial)_____FINANCIAL RESPONSIBILITY:
1. I understand that I am ultimately responsible for payment on my account & Payment is expected at the time of service.
2. I understand that I am responsible for any referral or authorization that my insurance may require and for any charges not covered by my insurance plan, including co-payments, co-insurance and deductibles.
3.CTOA will file claims for companies we are contracted with, including Medicare, Medicaid and Tricare . Payment of benefits will be made directly to Central Texas OB/GYN Associates.
4. *I understand and accept that if I make payment with a check and that check is dishonored or returned for any reason , CTOA will assess an additional fee of $35 to my account.*
5. *I understand that if I do not pay all of the charges due from me, my past due account may be turned over to an outside collection agency.*
6. I authorize CTOA, its assignees and third party collection agents to use all contact information I have provided. This may include voice or text messages, pre-recorded, artificial and auto-dialing services to my home, cell or work phone.

(Initial)_____INSURANCE COVERAGE: I understand that I am responsible for providing my physician with any and all insurance coverages at each and every visit. I will be responsible for any balances due as a result of not disclosing this information. *(_____ Staff Initials)*

(Initial)_____LABORATORY FEES: I understand that my physician uses Clinical Pathology Laboratory (CPL). CTOA cannot guarantee my insurance will cover any lab/pathology performed at or ordered by my physician. If my insurance requires use of a different lab, I understand it is my responsibility to inform my physician for proper handling.

(Initial) _____I DO CONSENT to necessary examinations and/or treatments performed and prescribed by my physician, mid level or behavioral health provider as is necessary in his/her judgment, with patient approval. **Separate consent forms will be signed for procedures performed in the physician's office.**

(Initial)_____PRESCRIPTIONS: I understand that CTOA uses electronic prescribing. My prescriptions will be sent
and my medication information may be obtained through CTOA's electronic prescribing function.

(Initial)_____RELEASE OF INFORMATION: I do hereby authorize my physician to release information to the hospital facility in the event of a scheduled surgery or procedure, emergency care or pregnancy. I authorize the release of
any medical records or other information necessary as required by my insurance company.

(Initial)_____HIPAA: I acknowledge that I have received or have access to a copy of CTOA's Notice of Privacy Practices. (**Office use only:** pt or pt's rep refused to sign due to _____staff initials_____)

(Inital)_____FEE FOR FORMS COMPLETION: I understand that I will be responsible for paying $15 for forms completion by my physicians or staff. (Example: Disability forms, FMLA forms, etc.)

(Initial)_____FEE FOR 'NO SHOW'. I understand that a $25 no show fee will be assessed for appointments that I do not keep. **Behavioral Health**: A $50 fee will be assessed for any appointment not kept or cancelled without 1 business day's notice.

I would like to receive ___**(Initial) E-mail** or ___**(Initial) text to my mobile device** regarding appointments.

Spouse/Partner's Name: _____ Spouse/Partner's Work Phone: _____

Spouse/Partner's Employer: _____ Spouse/Partner's Occupation: _____

Emergency Contact: _____ Emergency Phone:_____
(other than spouse)

Your signature: _____ Today's date:_____