NEW LIFE OBGYN ASSOCIATES

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Information regarding patient for whom authorization is made:

Full Name: _____Date of Birth: _____ SSN _____

Address: _____City:_____ State:_____ Zip _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name:_____

Information regarding person or entity who can receive and use this information:

Name:New Life OBGYN Associates

Address: 4302 South Sugar Road, Suite 201, Edinburg Texas 78539

Phone: (956) 277-1541 Fax: (956) 380-4433

Specific information to be disclosed:

□ Medical Record from (insert date) _____to (insert date) _____

□ Prenatal records, operative report, pathology report, imaging study reports, office visit notes

□ Other:_____

Purpose or request:_____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and**SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative:_____ Date:_____

If Legal Representative, relationship to Patient:_____

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Patient Portal

New Life OBGYN Associates uses a "patient portal" to allow you to access your electronic health record. We recommend all our patients to have this set up. It will allow for you to:

1. Request medication refills
2. Request appointments
3. Send and receive messages from your care team
4. View your medical record
5. View lab results

Name: _____ DOB: _____

Email address (please print clearly): _____

To opt out of the patient portal, please check one of the options below:

☐ I am not interested in signing up for the portal at this time ☐ I do not have an e-mail address

Portal del Paciente

New Life OBGYN Associates utilizar un "portal de pacientes" para permitirle el acceso a su expediente médico electrónico del paciente. Recomendamos a todos nuestros pacientes registrarse para obtener acceso. Vamos a permitir que:

1. Solicitud de rellenar medicamentos
2. Solicitud de citas
3. Envie y reciba mensajes seguros de su equipo de cuidado
4. Ver su expediente médico

Nombre: _____ Fecha de Nacimiento: _____

Dirección de correo electrónico: _____
(por favor imprima claramente)

Para optar por el portal del paciente por favor marque una de las siguientes opciones:

☐ No estoy interesado en inscribirme en el portal en este momento ☐ No tengo dirección de correo electrónico

Patient Medical Privacy Form

Receipt Acknowledgement for the Notice of Privacy Practices

I, _____, have been made aware of the Notice of Privacy Practices for New Life OBGYN Associates. I understand that this notice states how New Life OBGYN Associates may use and disclose my Protected Health Information (PHI). This includes leaving patient-related information on your voicemail. I understand that a copy of this notice is available upon request.

This includes appointment reminders by text, phone, or email and leaving patient-related information on your voicemail. I understand that a copy of this notice is available upon request. If you do not desire these forms of communication, please express your desire: _____

Medical Records Release and Forms

I understand that if I request a copy of my medical records be send to another doctor, I must allow 5 business days for processing from the time I submit a signed authorization. I understand that if I request my medical records to be released to me, I must pre-pay $10 and allow 5 business days for processing time from the time I submit a signed authorization. I understand if I submit a diability form, Family Medical Leave Act form, or any other form that requires a doctor signature and/or specific information to be completed, I will be charged $25 per form and allow 10 business days for processing.

I, _____, hereby authorize New Life OBGYN Associates to release any information, in the course of my treatment, necessary to process insurance claims and/or to any other requesting physician in reference to referrals or coordination of care.

Release of Records to a Designated Third-Party

I, _____, hereby authorize New Life OBGYN Associates to release and discuss my medical/billing information and records to the following individuals. (This should include friends or family members responsible for picking up your records when you are unable to do so). PLEASE PRINT.

1. _____ Relationship to Patient: _____

2. _____ Relationship to Patient: _____

By signing below I am verifying that I have read each of the three sections on this page. I understand each section and consent to and agree with the information stated in each section.

Patient Signature: _____ Date: _____

Legal Representative Signature: _____ Relationship to Patient: _____

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Patient Media Consent

I authorize New Life OBGYN Associates to photograph, videotape, or interview myself and immediate family and I authorize New Life OBGYN Associates to publish and use such materials or any portions thereof at its sole discretion and in any manner it desires; including but not limited to, information and education to the public, as well as to commercially promote, advertise, and/or market services. I hereby waive any right to compensation for New Life OBGYN Associates' use of such materials which display my likeness, photographs, image, voice, statements, and name and release New Life OBGYN Associates and its employees and agents from liability for any causes of action or claims of damages relation to use of such materials including, but not limited to, any claims of invasion or privacy, defamation, infringement of my right of publicity, or copyright infringement. I understand and acknowledge that any photograph, videotape, audiotape, and printed or published materials could be reproduced by unknown persons or organizations and republished via internet or other media without my knowledge or consent.

I recognize and understand that I may be providing and disclosing my protected health information of which I would have the right to full confidentiality and privacy to authorize New Life OBGYN Associates to publicize and/or reproduce such protected health information as referenced above and release and waive any claims against New Life OBGYN Associates, its employees, agents, officers, and directors from any causes of action or claims or damages relating to the disclosure of such information and the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) or any other law. As referenced below, I have the right to revoke this authorization. However, I acknowledge and agree that any revocation of this authorization will not change any actions that New Life OBGYN Associates took before I did so and it will be able to use and disclose the information I provided to the revocation.

_____	_____
Printed Name	Patient Date of Birth
_____	_____
Patient or Patient Representative Signature	Date of Authorization
_____	_____
If Patient Representative, Relationship to Patient	Representative Printed Name

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Assignment of Benefits Form

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to New Life OBGYN Associates rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize New Life OBGYN Associates to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from New Life OBGYN Associates on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Witness Date

Patient Demographics

Patient Information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (circle) M / F	Date of Birth	Marital Status (circle) Divorced | Married | Separated Single Widowed | Other	Primary Care Physician

Preferred Language (circle) English Spanish	Race (circle) Asian | Black | White | Other: _____	Ethnicity (circle) Hispanic | Not Hispanic | Unknown

Mailing Address	Apt/Lot	City/State	Zip	Cell: Home: Work:

Email Address	How did you hear about us?	Referring Physician

Responsible Party (Check if same as [ ] Patient)

Last Name	First Name	Gender (circle) M / F	DOB	Relationship to Patient

Mailing Address	Apt/Lot	City/State	Zip	Cell: Home: Work:

Employer Information

Employer	Address	City/State	Zip

Emergency Contact (Check if same as [ ] Responsible Party)

Last Name	First Name	Gender (circle) M / F	DOB	Relationship to Patient

Mailing Address	Apt/Lot	City/State	Zip	Cell: Home: Work:

Guardian Contact (Check if same as [ ] Responsible Party [ ] Emergency Contact)

Last Name	First Name	Gender (circle) M / F	DOB	Relationship to Patient

Mailing Address	Apt/Lot	City/State	Zip	Cell: Home: Work:

Insurance Information (Check if [ ] Self Pay)

(Check if same as [ ] Responsible Party)			(Check if same as [ ] Responsible Party)		
Subscriber/Member Name		DOB	Subscriber/Member Name		DOB
Relationship to Patient		Gender (circle) M / F	Relationship to Patient		Gender (circle) M / F
Primary Insurance Company		Begin Date	Secondary Insurance Company		Begin Date
Insurance Mailing Address	City/State	Zip	Insurance Mailing Address	City/State	Zip
Subscriber/Member #		Group #	Subscriber/Member #		Group #

Patient/Legal Guardian Signature Date

Patient/Legal Guardian Name

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1. **Insurance** - We participate in most insurance plans. Please note that if you are not insured by an insurance plan that we accept, payment in full is required at each visit. Also, if you are insured by a plan we are contracted with, but your benefits cannot be verified before your visit, payment in full for each visit is required. _____ **(Initials)**

2. **Co-payment and Deductibles Payment** - The patient or their guarantor is responsible for payment for services provided to them by New Life OBGYN Associates. All co-payments and deductibles must be paid at the time of service when rendered by the provider. This arrangement is part of our contractual written agreement with the insurance company (to include federal agencies). Because of this, your co-pay cannot be waived. In many cases, we verify with your insurance, your co-payment and deductible, however, there may be times that this is not possible. It is your responsibility for checking your insurance plan regarding your coverage: co-payments and deductibles. _____ **(Initials)**

3. **Non-covered Services** - For a variety of reasons, some or all of the services you receive may not be a covered benefit by your insurance plan. You are responsible for payment in full for any of these non-covered services at the time of the visit. We also ask Medicare-eligible patients to sign an Advance Beneficiary Notice (ABN) for the services which may not be covered. _____ **(Initials)**

4. **Personal Information** - All patients when signing in at the front desk are required to fill out a personal information form before seeing their physician. In addition, we ask that you provide us your drivers license and your current insurance cards (primary and secondary, if applicable) so that a copy of both documents can be made and then filed in your chart. We know that personal information sometimes changes: telephone numbers, last name, home/mailing address or even insurance plans. This is why our receptionist verifies your information at every visit. We thank you in advance for being patient with us during this necessary process. _____ **(Initials)**

5. **Claims Submission** - We will process a claim to your insurance company quickly so it can be paid with minimal delay. Your insurance company may need you to supply certain information directly to us. We ask for your help in getting the required information. A member of our business office may call you for more information to process your claim. _____ **(Initials)**

6. **Method of Payment** - We accept cash, debit, Visa, Mastercard, Discover and American Express. EFT drafting may be available for payment plans. Carecredit can be used when cost of service exceeds $400. _____ **(Initials)**

7. **Missed Appointments-** We understand that there are times when you must miss an appointment. However, when you do not call to cancel an appointment, you are preventing another patient from being seen. New Life attempts to confirm your appointment 1 business day prior to your appointment. If you do not confirm, your appointment will be given to another patient (there is a waiting list). New Life will reschedule your appointment once. If 2 or more no show appointments occur, and you continue to desire to see one of our providers, you will then be given a specific day and time range, versus being able to make your own appointment. _____ **(Initials)**

8. **Delinquent Accounts** - Patients whose account balances are older than 45 days are considered delinquent. Please pay your invoice within 30 days of statement being sent to mailing address. Payment in person, over the phone, or through the mail. _____ **(Initials)**

9. **Monies given prior to coverage:** Patients who have entered into a "private pay" plan, or insured patients that have a financial agreement for obstetrics services will not be refunded any monies previously collected if Medicaid Coverage is approved. The approved Medicaid coverage will be used following the first month after your effective date of the Medicaid card. (i.e. if a Medicaid letter states effective February, and you are seen in the office in March, then we will bill Medicaid going forward from the later date). For services paid on the same month you are effective and previous payments for rendered services will not be refunded or billed to Medicaid. _____ **(Initials)**

10. **Transferring care to another practice:** If you are an insurance obstetric patient and decide to transfer, you will be billed as an non-obstetric patient for the first three office visits that were provided for your care. After 4 or more visits, a partial obstetrics code will be submitted for payment. _____ **(Initials)**

11. **Payment plans** that have been formed need to be paid on the schedule set and agreed upon. (If OB, plans need to be paid by 34 weeks). _____ **(Initials)**

12. **Late to your appointment**, please call if you are going to be late. After 15 minutes, we may need to reschedule your appointment, or will try to work you in as a walk-in. _____ **(Initials)**

13. Certain aesthetic services/products need to be purchased in full prior to making appointment. _____ **(Initials)**

14. I have read all of the information above and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. In the event that my insurance company is billed, I authorize payment of medical benefits to be paid directly to New Life OBGYN Associates. A photocopy of this agreement shall be considered as effective and valid as the original copy. _____ **(Initials)**

Our billing office is EMS at (956) 688-6006.

Print Patient Name:_____ DOB: _____

Signature of Patient or Responsible Party: _____ Date: _____