Austin Maternal-Fetal Medicine			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

PATIENT INFORMATION

□ Dr. □ Miss □ Mrs. □ Ms.	Social Security Number _____ - _____ - _____	Previous Name (if any)
Address	City, State	Zip
Home Phone	Cell Phone	Work Phone
Primary Care Dr. (not for pregnancy): Full Name, Address, Phone	Referring OB: Full Name, Address, Phone	
Sex: □ Female □ Male □ Transgender	Pharmacy Name, Address	Pharmacy Phone
Race: □ American Indian/Alaskan Native □ Asian □ Black/African American □ Native Hawaiian/Pacific Islander □ White □ Declined	Ethnicity: □ Hispanic/Latina □ Not Hispanic/Latina □ Declined	
Marital Status: □ Married □ Single □ Divorced □ Widowed □ Legally Separated □ Partner	Language: □ English □ Spanish □ Indian □ Japanese □ Chinese □ Korean □ French □ German □ Russian □ Other _____	
Employment Status: □ 1-Full Time □ 2-Part Time □ 3-Not Employed □ 4-Self-Employed □ 5-Retired □ 6-Active Military	Employer Name	
Student Status: □ F-Full Time □ P-Part Time □ N-Not a Student	Do you have a living will? □ Yes □ No	

EMERGENCY CONTACT INFORMATION

Last Name	First Name	Relationship (or □ Guardian)
Address, City, State, Zip		
Home Phone	Cell Phone	Work Phone

RESPONSIBLE PARTY INFORMATION (used for patient balance statements)

□ Self **-OR-** □ Guarantor □ Other _____ Relationship _____ □ Info is the same as patient

Last Name	First Name	MI	Sex: □ Female □ Male
Address, City, State, Zip			Phone
Date of Birth (MM/DD/YYYY)	Social Security Number _____ - _____ - _____		
Employer Name	Employer Phone		

PRIMARY INSURANCE INFORMATION (please provide card to front desk at check-in)

Insurance Company	Phone Number
Name of Insured	Insured DOB (MM/DD/YYYY)

SECONDARY INSURANCE INFORMATION (please provide card to front desk at check-in)

Insurance Company	Phone Number
Name of Insured	Insured DOB (MM/DD/YYYY)

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PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

NOTICE OF PRIVACY PRACTICES OF AUSTIN MATERNAL-FETAL MEDICINE (AMFM)

Pat/Rep Init

I acknowledge that I have received AMFM's Notice of Privacy Practices which describes the ways in which AMFM may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the provider and/or the provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in AMFM's Notice of Privacy Practices.

CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATIONS

Pat/Rep Init

I agree that, in order for AMFM or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that AMFM or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or AMFM or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

RELEASE OF INFORMATION

I hereby permit AMFM and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA-affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Workers' Compensation.
- If I am covered by Medicare or Medicaid, I authorized the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment, and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions, and/or infectious diseases including but not limited to bloodborne diseases such as HIV and AIDS.

CONSENT FOR PHOTOGRAPHING OR OTHER RECORDING FOR SECURITY AND/OR HEALTHCARE OPERATIONS

Pat/Rep Init

I CONSENT to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes, and/or AMFM's healthcare operations purposes (e.g. quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible, unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

-OR-

Pat/Rep Init

I DO NOT CONSENT to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes, and/or AMFM's healthcare operations purposes (e.g. quality improvement activities).

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CONSENT TO EMAIL, CELLULAR TELEPHONE, OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

We want to stay connected with our patients. AMFM patients may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time you provide an email address, cellular telephone number, or text number below, you understand that you may get these communications from AMFM. You may opt out of these communications at any time (see next page). AMFM does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I CONSENT to receive appointment reminders, feedback, and general health reminders/information via:			***I DO NOT CONSENT*** to receive appointment reminders, feedback, and general health reminders/information via:	
Email	☐ Pat/Rep Init	**-OR-**	Email	☐ Pat/Rep Init
Email Address _____				
Cellular Telephone	☐ Pat/Rep Init	**-OR-**	Cellular Telephone	☐ Pat/Rep Init
Text Usage	☐ Pat/Rep Init	**-OR-**	Text Usage	☐ Pat/Rep Init

Patient/representative may revoke or modify this specific authorization, and that revocation or modification must be in writing.

NOTE: *AMFM uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information also will be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.*

DISCLOSURE TO FRIENDS AND/OR FAMILY MEMBERS

☐ Yes ☐ No **Do you want to designate a family member or other individual with whom the provider may discuss your medical condition?** If "yes", I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1.			
2.			
3.			

Patient/representative may revoke or modify this specific authorization, and that revocation or modification must be in writing.

PRESCRIPTION ORDER PICK-UP

There may be times when you need a friend or family member to pick up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

☐ Pat/Rep Init ***I DO WANT*** to designate the following individual(s) to pick up a prescription order on my behalf:

Name	Date

-OR-

☐ Pat/Rep Init ***I DO NOT WANT*** to designate anyone to pick up my prescription order.

Patient/representative may revoke or modify this specific authorization, and that revocation or modification must be in writing.

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FINANCIAL RESPONSIBILITY

Pat/Rep Init

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to AMFM and/or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify AMFM of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by AMFM and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

ASSIGNMENT OF BENEFITS

Pat/Rep Init

I authorize direct remittance of payment of all insurance benefits, including Medicare if I am a Medicare beneficiary, to AMFM for all covered medical services and supplies provided to me during all courses of treatment and care provided by AMFM and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by AMFM, and will constitute a continuing authorization, maintained on file with AMFM, which will authorize and allow for direct payment to AMFM of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies, and/or care provided to me by AMFM.

INSURANCE COVERAGE WAIVER

Pat/Rep Init

I acknowledge that AMFM does not accept all insurance plans. I understand that I am financially responsible for all services and/or supplies received in the event my insurance is not accepted by AMFM. I understand my insurance may not be confirmed at this time; however, I wish to receive service and care from AMFM. I understand the below list of insurance plans not accepted by AMFM is not a complete list and it is my responsibility to ensure my insurance plan is accepted by AMFM.

AMFM does NOT accept the following insurance plans:

- Seton Medicaid (including Chip and Dell's Children Plan)
- Seton EPN
- Covenant Management Systems by Seton Health Plan
- Scott and White including Right Care
- Cook Children's Star and Chip plans
- Aetna EPO
- Humana X

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature, even after a specific diagnosis has been made and treatment recommended, and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

_____	_____	_____
Patient/Representative Signature	Relationship to Patient	Date

** OFFICE USE ONLY **

_____	_____	_____	_____
Printed Name of Witness	Witness Signature	Employee Job Title	Date