

**Arlington Perinatal Associates, P.A.**  
515 W. Mayfield Road, Bldg. A, Suite 304  
Arlington, Texas 76014  
(817)467-1010

**PATIENTS NAME:** \_\_\_\_\_

LAST

FIRST

M

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_ **CELL:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**SOCIAL SECURITY #:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**MARITAL STATUS:** \_\_\_\_\_ **MARRIED** \_\_\_\_\_ **SINGLE** \_\_\_\_\_ **OTHER** \_\_\_\_\_

**RACE:** \_\_\_\_\_ **PRIMARY LANGUAGE:** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ **DRIVER'S LICENSE #:** \_\_\_\_\_

**PRIMARY INSURANCE \*\*\*IF YOU WOULD LIKE US TO BILL YOUR INSURANCE, YOU MUST COMPLETE EACH BLANK**

**INSURANCE COMPANY:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**POLICY HOLDER'S EMPLOYER:** \_\_\_\_\_ **POLICY #:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**CLAIMS MAILING ADDRESS:** \_\_\_\_\_ **RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**POLICY HOLDER'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **POLICY HOLDER'S SS#:** \_\_\_\_\_

**SECONDARY INSURANCE \*\*\*IF YOU WOULD LIKE US TO BILL YOUR INSURANCE, YOU MUST COMPLETE EACH BLANK**

**INSURANCE COMPANY:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**POLICY HOLDER'S EMPLOYER:** \_\_\_\_\_ **POLICY #:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**CLAIMS MAILING ADDRESS:** \_\_\_\_\_ **RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**POLICY HOLDER'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **POLICY HOLDER'S SS#:** \_\_\_\_\_

**REFERRING PHYSICIAN:** \_\_\_\_\_ **REASON FOR APPOINTMENT:** \_\_\_\_\_

**LAST MENSTRUAL PERIOD:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_ **DRUG ALLERGIES:** \_\_\_\_\_

**TOTAL NUMBER OF PREGNANCIES:** \_\_\_\_\_ **NUMBER OF LIVING CHILDREN:** \_\_\_\_\_

**OTHER CONDITIONS/COMPLICATIONS:** \_\_\_\_\_

I authorize the physicians and /or qualified staff to perform upon me, ultrasound and/or any other care including treatment necessary for the well being of me and/or my unborn child. I acknowledge that the practice of medicine and/or ultrasound is not an exact science and that no guarantees can be made to me as to the outcome of treatment and/or my pregnancy.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

I authorize any and all insurance carriers for which I have coverage be billed and payment be made directly to Arlington Perinatal Associates, 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.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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 Arlington Perinatal Associates, PA.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Arlington Perinatal Associates, PA  
515 W. Mayfield Road, Ste. 304, Arlington, Texas 76014  
Phone (817)467-1010 Fax (817)419-2626

## **FINANCIAL POLICY**

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, Personal Check, Care Credit, MasterCard, and Visa. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due **prior** to these services being provided. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over 90 days with no payment activity will be reported to the credit bureau(s).* Initials \_\_\_\_\_
- **Your insurance policy is a contract between you and your insurer. Do not assume your policy covers everything or pays at 100%. It is your responsibility to know what your policy covers and what it does not. We cannot quote your benefits.** Any item deemed "non-covered" by your insurance carrier will be your financial responsibility. This includes lab designation and payment. Any disputes about payment must be resolved between you and your insurer. You are responsible for ensuring a properly dated referral and/or authorization if required by your insurer for services being provided. You are also responsible for payment if your claim denies for lack of referral/authorization. Failure to provide accurate insurance information within 3 days from the date of service will result in the balance becoming your financial responsibility. Initial \_\_\_\_\_
- As a courtesy to you, we will file primary participating insurance for you with proper assignment. Any additional insurance policies will be yours to file with receipt from our office. Please bring your primary insurance card with you to every visit. I understand that all remaining balances are my responsibility to satisfy prior to additional services being rendered. Initial \_\_\_\_\_
- This office is not party to legal disputes. The financial responsibility rests with the patient or parent/guardian for patients under 18 years of age. Initial \_\_\_\_\_
- A \$35.00 fee will be assessed for all returned checks. Initial \_\_\_\_\_
- We confirm appointments 48 hours in advance. Please notify our office within 24 hours before scheduled appointment to avoid a \$25.00 cancellation fee. Initial \_\_\_\_\_
- Payments & credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service. Refunds over \$50 will be provided within 30 days from the date all outstanding claims are satisfied. Credit balances less than \$50 will be available and processed upon request of the patient. Initial \_\_\_\_\_

### ASSIGNMENT OF BENEFITS

I request payment of the medical benefits, otherwise payable to me, directly to *Arlington Perinatal Associates, PA* for services provided by them.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

\_\_\_\_\_  
Responsible Party Printed Name (Must be 18 or over)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Responsible Party Signature (Must be 18 or over)

\_\_\_\_\_  
Date



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Arlington, TX 76014  
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### **Consent for Images**

Please select emailed images or printed by initialing **one**.

#### **I want printed images \_\_\_\_\_**

I understand I am declining the option to have my ultrasound images emailed to me and will receive printed images (maximum 3 images). I understand that if I wish to receive them via email for future visits I must complete a new consent form.

\*\*\*\*\*OR\*\*\*\*\*

#### **I want emailed images \_\_\_\_\_**

I understand that I am opting to receive my ultrasound images by email and I will not be provided printed images. Due to fetal positioning and ultrasound capabilities I am aware that the number of images may vary per visit. I understand that due to limited capabilities I will receive one email of my images and that it is solely my responsibility to secure my images once received.

I understand that this service is provided as a courtesy and not a necessity of medical care. I further understand that all identifying information such as name and medical record identification numbers are removed from the image for my protection.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Email Address

### **Privacy Statement**

This notice serves as confirmation that a current copy of Arlington Perinatal Associates' Notice of Privacy Practices has been provided to me. I understand that my "protected health information" includes health information, including demographic and financial information I have provided or has been received from another health care provider, health plan, employer, or insurance company. This information may include information on HIV, AIDS, alcohol use, drugs and medication. This protected information relates to my present, past and future physical and mental health or condition. I understand that I have the right to revoke or change this authorization, in writing, at any time by providing written notification to the office at the address above.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

I understand that my physician will not disclose the condition of my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) unless I provide authorization for disclosure.

I authorize Arlington Perinatal Associates, PA, its physicians, and staff to disclose the above protected health information (such as; test results, diagnoses, and any information regarding my care) to the person(s) listed below. I understand the information used or disclosed to the following individuals will no longer be protected by federal or state law.

\_\_\_\_\_  
Name Relationship: Significant Other/Parent/ Other: \_\_\_\_\_

\_\_\_\_\_  
(Contact Phone Number)

\_\_\_\_\_  
Name Relationship: Significant Other/Parent/ Other: \_\_\_\_\_

\_\_\_\_\_  
(Contact Phone Number)