OBGYN Obstetrical & Gynecological Associates of Des Moines p.l.c.

Authorization and Consent for Treatment

Patient Name:_____ Date of Birth:_____

Social Security #:_____ Marital Status:_____

Address:_____

City, State, Zip:_____

Email:_____

Race:_____ Ethnicity:_____

Home Phone:_____ Cell Phone:_____

Employer:_____Work Phone:_____

Spouse Name:_____ Spouse DOB:_____

Does your insurance require a specific lab? Yes_____ No_____

If so, which lab is required? _____
(We send lab specimens to Mercy unless you request otherwise.)

I request and authorize health care services by my provider as he/she deems advisable and in my best interest. This may include routine diagnostic, radiology and laboratory procedures as well as medication administration and drug screening during pregnancy. I authorize OBGYN Associates of Des Moines PLC to release my immunization information to the state registry. I also agree that OBGYN Associates of Des Moines PLC can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

I hereby authorize the release of any information acquired in the course of my examination or treatment for the processing of an insurance claim. I also request that payment of authorized Medicare benefits and any other insurance benefits be made to OB/GYN Associates of Des Moines, PLC for any services provided to me by them.

By signing this consent form, I agree to pay OB/GYN Associates of Des Moines, PLC for any co-insurance, co-payments, deductibles orother amount not paid for by insurance. Failure to do so may result in collection action or denial of future treatment.

Signature:_____Date:_____

Relationship to Patient (if applicable):_____

Please email this completed form to transcription@obgyndm.com