OBSTETRICAL & GYNECOLOGICAL associates p.l.c.

Authorization and Consent for Treatment

Patient Name:_____Date of Birth:_____

Social Security #:_____Marital Status:_____

Address:_____

City, State, Zip:_____

Email:_____

Due to certain testing that may be done, we will need race and ethnicity information.
Please select your race and ethnicity:

Race:
- ☐ African American/Black
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Pacific Islander
- ☐ White/Caucasian
- ☐ Other: (Specify) _____
- ☐ Decline to report

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Decline to Report

Home Phone:_____Cell Phone:_____

Employer:_____Work Phone:_____

Spouse Name:_____Spouse DOB:_____

Insurance Policy Holder/Relationship: _____ Policy Holder DOB: _____

Do you have Iowa Medicaid/Amerigroup/Iowa Total Care insurance? Yes_____No _____

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 medicationadministration 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 payers 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 or other amount not paid for by insurance. Failure to do so may result in collection action or denial of future treatment. I understand that OBGYN Associates will charge a $50 fee per visit for any no show or same day cancel without a 24 hour notice. I acknowledge OBGYN Associates has a discharge policy after three no shows.

Signature:_____Date:_____

Relationship to Patient (if applicable):_____

Please email this completed form to transcription@obgyndm.com