

PATIENT INFORMATION (Please print legibly/Escribir legible)

Name/Nombre: last/apellido		first/nombre	<input type="checkbox"/> Male Masculino	<input type="checkbox"/> Female Femenino	Patient #
Address/Domicilio: Número y calle		Home Phone/Teléfono de la casa		Work Phone/No. de Teléfono del trabajo	
		Social Security Number/Número de Seguro Social			
City/ Ciudad	State/Estado	Zip/Zona Postal	Genetic Counselor Kathryn Davis		Date of Appointment

CLIENT INFORMATION

Austin Perinatal Associates
148832/148834
6500 N. Mopac Bldg 1 Ste 1205
Austin TX 78731

BILLING/INSURANCE INFORMATION / INFORMACIÓN DE SEGURO PARA COBRO

(Complete Section 1 if you are paying by cash OR Section 2 to have your insurance company billed.)

(Llenar sección 1 si pago es en dinero efectivo. Llenar sección 2 si quiere que su cuenta sea enviada a su seguro médico.)

<p>SECTION 1:</p> <p><input type="checkbox"/> Physician or Institution/Doctór ó Institución</p> <p><input type="checkbox"/> Medicare: (Copy of card required/Copia de la tarjeta)</p> <p style="padding-left: 20px;"><input type="checkbox"/> Inpatient/Paciente hospitalizado</p> <p style="padding-left: 20px;"><input type="checkbox"/> Outpatient/Paciente no hospitalizado</p> <p>Card # / # de la tarjeta: _____</p> <p><input type="checkbox"/> Medicaid: (Copy of card required/Copia de la tarjeta)</p> <p>Card # / # de la tarjeta: _____</p> <p>State/Estado: _____</p> <p><input type="checkbox"/> California PNS Program</p> <p><input type="checkbox"/> Patient/Self-Pay/Cobro al paciente</p> <p><input type="checkbox"/> Payment Enclosed/Pago incluido</p> <p><small>* Do not attach credit card information to this form</small></p>	<p>SECTION 2: Copy of insurance card (front & back) required, attach copy of authorization if available.</p> <p>Copia de la tarjeta del seguro (parte delantera y posterior), adjuntar copia de la autorización si está disponible.</p> <p><input type="checkbox"/> Insurance/PPO/Seguro/PPO</p> <p><input type="checkbox"/> Blue Cross/Blue Shield</p> <p><input type="checkbox"/> Medical Group/IPA*</p> <p style="padding-left: 20px;">Attach co-pay/Adjuntar co-pago</p> <p><input type="checkbox"/> HMO*</p> <p style="padding-left: 20px;">Attach co-pay/Adjuntar co-pago</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>*Authorization #</p> <p>*# de autorización</p> </div> <p style="margin-top: 10px;"><i>Non-authorized services will be billed to the patient.</i></p> <p style="margin-top: 5px;"><i>Servicios no autorizados serán cobrados a Usted.</i></p>
	<p>Insurance Co Name/Nombre de la compañía de seguro: _____</p> <p>Billing Address/dirección de la compañía: _____</p> <p>City, State, Zip/Ciudad, Estado, Zona postal: _____</p> <p>Telephone # / # de teléfono: _____</p> <p>Name of Insured/Nombre del asegurado: _____</p> <p>Policy # / # de la póliza: _____ Group# / # del grupo: _____</p> <p>Name of Employer/Nombre del empleador: _____</p> <p>Relation to Insured/Parentesco con asegurado: Self/Asegurado Spouse/Cónyuge Child/Hijo/a Other/Otro</p>

The charge for these services is separate from any other tests or procedures. I authorize Integrated Genetics to furnish my designated insurance carrier any information concerning my services that is necessary for reimbursement. I also authorize benefits to be payable to Integrated Genetics. I understand that I am responsible for any amount not paid by insurance.

Many insurance carriers will pay only for services they deem to be reasonable and necessary or a covered service. If my insurance carrier determines that a particular service is not reasonable and necessary, my insurance carrier may deny payment. If my plan does not cover the genetic counseling or medical consult provided by Integrated Genetics, I agree to be responsible for full payment.

Signed _____ Dated _____

El cobro de estos servicios son aparte de cualquier otro examen o procedimiento. Yo autorizo que Integrated Genetics supla a mi seguro médico de cualquier información que sea necesaria para reembolso. Yo también autorizo que los beneficios sean pagados a Integrated Genetics. Yo entiendo que soy responsable por cualquier cantidad que no sea pagada por mi seguro médico.

Muchos seguros médicos solamente pagan por servicios que consideran razonables o necesarios. Si mi seguro determina que algún servicio en particular no es considerado razonable o necesario, mi seguro médico puede negar pago. Si mi plan no cubre la charla con la consejera genética o consulta médica provista por Integrated Genetics, yo accedo hacerme responsable por la cuenta en completo.

Firma _____ Fecha _____

Patient Information & Pregnancy Questionnaire

Name (First): _____ (Last): _____

Date of Birth (M/D/Y): _____ Occupation: _____

Address: _____ City: _____

State: _____ Zip: _____ County (CA only): _____

Contact Info: Home #: _____ Cell: _____ Work: _____

PARTNER INFORMATION (if the patient is pregnant, then "partner" is the father of the pregnancy)

Name (First): _____ (Last): _____

Date of Birth (M/D/Y): _____ Occupation: _____

REFERRING PHYSICIAN INFORMATION:

Name: _____ Phone #: _____

Address: _____ City: _____

PREGNANCY AND EXPOSURE INFORMATION

Are you currently pregnant? NO YES Due date: _____

Have you taken any medications during this pregnancy (besides prenatal vitamins or Tylenol)? NO YES
If yes, please list:

Since becoming pregnant, have you had any:
(or if not pregnant please check current exposures)

- Recreational Drugs NO YES _____
- Cigarettes NO YES _____
- Alcohol NO YES _____
- Fevers NO YES _____
- X-rays NO YES _____

Do you have any of the following conditions?

- Diabetes? NO YES _____
- A seizure disorder? NO YES _____

CONFIDENTIAL or PRIVATE MESSAGES:

Integrated Genetics/Esoterix Genetic Laboratories, LLC has my permission to leave detailed messages about **confidential medical information and test results** at the number(s) noted below. YES NO (if no, proceed to the signature box)

Preferred confidential phone number: Home Cell Work Other: _____

Who else can we leave test results with? _____ Phone: _____

ALL OF THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE: _____ DATE: _____