Woman's Health Group dba James R. McBride, M.D.
7580 Fannin, Suite 335, Houston, Texas 77054
713-797-9171 fax 713-797-0493

Patient's Name (Last) _____ (First) _____ (MI) ___ Previous Name _____

Address Line 1 _____

City, State _____ ZIP_____ Pharmacy_____Pharmacy Phone_____

Home Phone _____ Cell No. _____ Work Phone _____Ext. _____

Referral Source : Website ___ Facebook___Twitter___Blog___Google Places___Family/Friend _____

Physican Referral _____Other_____

E-Mail Address:_____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ Transgender

Race ☐ American Indian ☐ Asian ☐ Black or African American ☐ White_____ Other_____ ☐Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined Language ☐ English ☐ Spanish ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Spouse Name _____ Spouse DOB _____ Spouse's Social Security _____ _____ _____

Social Security _____ ____ _____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student ☐

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP_____

Home Phone _____ Work Phone _____ Ext. _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Spouse Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer_____ Employer Phone Number_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____ (_____)_____

Name of Insured_____ Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ Date of Birth MM _____/DD _____/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____ (_____)_____

Name of Insured_____ Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____Date of Birth MM _____/DD _____/YYYY____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

James McBride MD., PLLC

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 recommend by your health care 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 health care 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 and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Relationship to Patient**

_____ _____

Printed Name of Witness Employee Job Title

_____ _____

Signature of Witness **Date**

Woman's Health Group
James McBride, M.D.

Assignment of Benefits

I, hereby acknowledge that I am to receive medical services from Woman's Health Group (James McBride, M.D.) In consideration of the services and treatment rendered, I hereby authorize and direct payment of medical benefits to aforementioned and assign any and all causes of action that I may against any insurance company (including all coverage for PIP and/or Med-pay, as a result of a vehicular accident), obligated to me by law, statute, or contractual agreement, for payment of such medical services and treatment. I direct my insurer to escrow any personal injury protection and/or medical payment benefits to disputes for services or treatments rendered to me by aforementioned physician,. I also authorize the release of any pertinent information or medical records to aforementioned physician, and any other medical provider, insurance company or attorney involved with my medical treatment or case and/or litigation, that is seeking to obtain payment for medical services and treatment rendered by aforementioned physician or others in its behalf. I hereby direct any insurance company carrier to provide a copy of the PIP log or benefit payout sheet as well as any written explanations as to payments or reductions made or denied or other correspondence pertaining to a claim for services or treatment rendered to me as specified herein.

A photocopy of this consent shall be considered as valid as the original.

_____ Initial and date

Guarantee of Payment

I guarantee payment for all charges not covered by my insurance, all applied deductibles and co-pays, **within 30 days of receiving a statement.**

_____ Initial and date