PLEASE PRINT

PATIENT NAME: FIRST MIDDLE INITIAL LAST YOUR BIRTH DATE:

ADDRESS: CITY: STATE: ZIP:

HOME PHONE: SOC. SEC. #: MARITAL STATUS: S ☐ M ☐ W ☐ D ☐

YOUR EMPLOYER: WORK ADDRESS:

WORK PHONE: CELL PHONE: YOUR INSURANCE:

SPOUSE'S NAME: SPOUSE'S BIRTH DATE:

SPOUSE'S SOC. SEC. #: SPOUSE'S EMPLOYER:

SPOUSE'S WORK PHONE: SPOUSE'S INSURANCE:

ARE YOU COVERED BY SPOUSE'S INSURANCE? YES ☐ NO ☐ IF YES, PLEASE PROVIDE INFORMATION

ANY OTHER HEALTH INSURANCE? YES ☐ NO ☐ IF YES, PLEASE PROVIDE INFORMATION

EMERGENCY CONTACT (NAME & PHONE NUMBER): YOU HAVE MY PERMISSION TO DISCUSS MY MEDICAL INFORMATION WITH:

MAY WE CONTACT YOU WITH OUR AUTOMATED APPOINTMENT REMINDER SYSTEM? ☐ YES ☐ NO

MAY WE LEAVE MEDICAL INFORMATION AT YOUR HOME TELEPHONE NUMBER? ☐ YES ☐ NO

PRIMARY PHYSICIAN INFORMATION:
NAME: ADDRESS: PHONE:

IF YOU ARE A MINOR, PLEASE COMPLETE THE FOLLOWING SECTION

MOTHER	FATHER
NAME:	NAME:
BIRTH DATE: SOC SEC #:	BIRTH DATE: SOC SEC #:
ADDRESS:	ADDRESS:
EMPLOYER:	EMPLOYER:
INSURANCE:	INSURANCE:

How did you hear about us? ☐ Family ☐ Friend ☐ Family Doctor ☐ Our Website ☐ Yellow Pages ☐ Other ______________________________

PLEASE PRESENT THIS FORM TO THE RECEPTIONIST WITH YOUR INSURANCE CARD(S)

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN:

I hereby authorize the physicians and staff of Women's OB-GYN, P.C. to release to my insurance company any information acquired in the course of my treatment, either verbally, in writing or via fax machine. This authorization also allows the release of information to another physician in the event it becomes necessary for you to be referred to another physician; it also allows the release of information to your primary care physician. This release specifically includes information with respect to communicable diseases or infections, including HIV virus (i.e., AIDS.) I further hereby authorize my insurance company to pay directly to the physicians of Women's OB-GYN, P.C. surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that amounts deemed by my insurance company to be beyond what they may consider "usual, customary, and/or reasonable" charges for said services will be paid in full by me. I also understand that I am fully responsible for any and all co-payment and deductible amounts. I understand that any service rendered to me that is not a benefit of my insurance company will be paid in full by me.

If any charge for services rendered to me by Women's OB-GYN, P.C. are not paid in a timely manner, the account may be turned over to a third party collection agency. Should my account be turned over to a collection agency, I hereby agree to pay the collection agency fee of 35%, in addition to the balance owed to the account.

I am aware that any and all referrals required by my insurance company are my responsibility. Should I fail to follow these rules, I will become fully responsible for payment of all charges. This authorization will remain in effect until revoked in writing by me with a copy of the revocation given to Women's OB-GYN, P.C. **Please be aware that if you should refuse to sign this form, we will be unable to render medical services to you.**

SIGNED: DATE:

I HAVE BEEN OFFERED OR RECEIVED A COPY OF THE WOMENS OB GYN, PC NOTICE OF PRIVACY PRACTICES. PLEASE INITIAL ☐

PLEASE NOTE: If you fail to keep three consecutive appointments without notifying us in advance, it will result in the termination of your care with this office. Also, please be aware that we do endeavor to treat each of you with kindness and respect at all times and ask that you treat each of our staff members the same.

Date:_________Init:________Date:_________Init:________Date:_________Init:_______Date:__________Init:________Date:______ Date:__________Init:_________

PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE

Please print all information, then sign and date form at bottom.

Patient Name ____ Chart Number _______________

Purpose of request - I authorize Women's OB Gyn, P.C. to disclose or provide my protected health information to the following individuals who are authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, they may exercise my right to inspect, copy, and correct my protected health information:

1.____ Relationship ________________

2.____ Relationship ________________

3.____ Relationship ________________

4.____ Relationship ________________

Description of information to be disclosed - I authorize Women's OB Gyn, P.C. to disclose all my protected health information to my designated personal representative.

Expirations or termination of authorization - This authorization will remain in efffect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to revoke or terminate - As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Redisclosure - We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed to them, under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

____ ___________________

Patient Signature Date