

PATIENT

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Home phone # \_\_\_\_\_ Medicare # \_\_\_\_\_ DL # \_\_\_\_\_ State \_\_\_\_\_

Work phone # \_\_\_\_\_ Cell phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Single  Married  Widowed  Divorced

Employment status:  Full time  Part time School:  Full time  Part time  Retired

Name of spouse/responsible party \_\_\_\_\_

Date of birth \_\_\_\_\_  Male  Female

His/her employer \_\_\_\_\_

Employer's address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Occupation \_\_\_\_\_ Work phone \_\_\_\_\_ Cell \_\_\_\_\_

Do you have insurance through your employer?  Yes  No

Insurance co. name \_\_\_\_\_  PPO  HMO  Other \_\_\_\_\_

Insurance co. address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

ID/Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Eff. Date \_\_\_\_\_

Employer \_\_\_\_\_

Employer's address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Occupation \_\_\_\_\_ Work phone \_\_\_\_\_ Cell \_\_\_\_\_

Do you have insurance through your spouse/responsible party?  Yes  No

If Yes, insurance co. \_\_\_\_\_  PPO  HMO  Other \_\_\_\_\_

Insurance co. address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

ID/Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Eff. Date \_\_\_\_\_

Relationship to patient:  Spouse  Father  Mother  Other

Employment status:  Full time  Part time School:  Full time  Part time  Retired

Primary care physician \_\_\_\_\_ Phone # \_\_\_\_\_

Referred by? \_\_\_\_\_

Notify in case of emergency:  Friend  Relative Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

PRIMARY INSURANCE

SECONDARY INSURANCE

Acknowledgments/Disclaimers/Assignment of Benefits

Our office makes every effort to maximize insurance payments. However, please be advised that certification of visits and procedures does not guarantee coverage by your particular plan. In addition, most insurance companies will not pre-determine or guarantee the dollar amount of benefits they will pay until after a procedure is done. Therefore, all fees for services rendered, as well as co-payments, deductibles, or fees not covered by your insurance plan are ultimately the responsibility of the patient, or in the case of a minor the financially responsible party. We do not assume responsibility for any errors or omissions in the pre-certification process or any benefits unpaid by your insurance company.

For these reasons, we strongly advise you to become familiar with your insurance plan in order to know and follow the specific guidelines for your particular contract.

I understand that the clinician seeing me may not be a contracted provider and I accept financial responsibility regardless.

I further agree to pay any charges unpaid for any reason.

I have read and understand the above and agree to the terms stated.

I authorize the release of any medical information necessary to process any insurance claim and request payment of insurance benefits to OB/GYN Women Physicians Assoc. Inc., DIRECTLY.

Signature (insured or authorized person)

Date

If you cannot keep an appointment, you must give us 24 hours notice. If you miss your appointment and do not give us notice and we are unable to fill it, our office reserves the right to charge a missed appointment fee of \$25.