CONTEMPORARY OBSTETRICS & GYNECOLOGY, PC

Patient Registration Form

Legal Name ____ Today's Date ________________

Date of Birth _____________________ Social Security Number ____________________________

Address _______________________________ City, State, Zip ____________________________

Home phone __________________________ Cell phone ______________________________

Work phone ___________________________ Occupation _____________________________

Employer ________________________________ Address _______________________________

Please circle which number(s) we may leave messages at: Home Cell Work

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If applicable, name of spouse _________________________ Daytime phone _________________

Emergency Contact _________________________________ Phone _______________________

Primary Care Physician / phone ____

How were you referred to our office? ☐ Primary Care Physician ☐ Yellow Pages ☐ Internet
☐ Friend / Family (name) ___________________________ ☐ Other ________________________

Primary Insurance ___________________________________ Effective Date ________________

Insured's Name _________________________ Group # __________ ID# _____________________

Date of Birth _____________ SS # _____________________ Employer _____________________

Insured's relationship to you: ☐ Self ☐ Spouse ☐ Parent ☐ Other ________________________

Secondary Insurance ___________________________________ Effective Date ______________

Insured's Name _________________________ Group # __________ ID# _____________________

Date of Birth _____________ SS # _____________________ Employer _____________________

Insured's relationship to you: ☐ Self ☐ Spouse ☐ Parent ☐ Other ________________________

Release of Information

By signing below, you understand that as defined by the privacy regulations pronounced pursuant to the Health Insurance Portability Accountability Act of 1996 (HIPAA), the information obtained or created about you must be safeguarded. We may use and disclose your individually identifiable health information for purposes of treatment, payment and health care operations. However, your personal health information (PHI) and accounting details will not be released to anyone else without your consent, except as allowed by law. Our detailed Privacy Policy is available in our reception area or you may request a copy be mailed to you by contacting our office at any time. By signing below I acknowledge that I was offered a printed detailed copy of HIPAA Notice of Privacy Practices.

Assignment of Insurance Benefits & Payment Policy

By signing below, you authorize your insurance benefits to be paid directly to Contemporary Obstetrics and Gynecology, PC or one of its physicians, understanding that you are responsible to pay all non-covered services or provider charges that may exceed insurance payment. You also authorize the release of pertinent medical information to your insurance carriers, Social Security Administration, Healthcare Financing Administration or intermediaries as required for claim/payment processing.

Co-pays, non-covered services and unmet deductibles are due at the time of the visit. We will gladly bill for these charges for an additional $15.00. We accept cash, Visa, Mastercard, Discover, and personal checks. A $10 billing fee is assessed every month in which a balance is carried over 30 days. We understand extenuating circumstances, if you need to make payment arrangements, please contact the billing department. There is a $35 fee for returned checks.

If you would like to allow medical information to be shared with family/friend, please list here:

____
Name | Relationship | Phone

____
Name | Relationship | Phone

By signing below, you authorize us to share medical information with the family/friend listed above and agree to abide by the policies described above. Further, all information you have provided is accurate to the best of your knowledge. If you wish to revoke this authorization, it must be done in writing.

Signature ____ Date ___________________

Relationship to patient (if not patient) ____

Notary