

Laurel Ob-Gyn, P.A. Patient Registration

Please Print

Today's Date				
<i>PATIENT INFORMATION</i>				
Full Legal Name (First) (Middle) (Last) (As stated on insurance card)				Name Normally Used (Nickname)
Mailing Address (Number) (Street) (Apt. No.)				
City	State, Zip	Social Security #	Home #	Cell #
Date of Birth	Age	Sex	Marital Status	Occupation
Employer Name	Employer Street Address	City	State	Zip
Business Phone (Including Extension)		Patient's Driver's License No.		State
Other Physicians You See			How did you hear about Laurel Ob-Gyn, P.A.?	
Responsible Party – Name, Address, Phone Number				
<i>Primary Insurance Holders INFORMATION</i>				
Full Legal Name (First) (Middle) (Last) (SS#) (DOB)				Occupation
Address (If Different from Above)		City	State	Zip
Home Phone				
Employer Name	Street Address	City	State	Zip
Business Phone				
<i>INSURANCE INFORMATION (Copy of card should be given to receptionist)</i>				
Primary Insurance Company Name			Group No.	ID/Certification No.
Secondary Insurance Company Name			Group No.	ID/Certification No.
<i>EMERGENCY INFORMATION</i>				
Person to Notify in Case of Emergency and Phone #				Relationship

Payment & Insurance Notice

Payment is due at the time services are rendered. If other financial arrangements are necessary, they must be made prior to treatment. Any partially paid balances are due and payable within 30 days from the date of service.

We will file insurance claims directly with your insurance company. In order to do so we must have accurate information regarding your insurance coverage. Payment of services rendered remains your responsibility, but we will be glad to assist you in obtaining benefits from your insurance carrier.

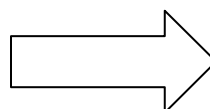
Increasing delinquency in payment of accounts has made it necessary to obtain written consent to guarantee payment and/or financial responsibility of all accounts. In the event that it is necessary to refer your account to an attorney or collection agency for collection, the undersigned hereby agrees to pay in addition to the balance due on the account, all of our costs for collection, including reasonable attorney's fees, collection agency fees, and expenses of collection, including but not limited to court filing and service fees.

I hereby authorize Laurel OB/GYN to furnish information to my insurance company concerning my care. I further hereby assign all payments for services rendered to Laurel OB/GYN. I understand that I am financially responsible for all services rendered.

I have read the above information and hereby acknowledge receipt of a copy of information and agree to terms stated herein.

DATE: _____

SIGNATURE: _____



Laurel Ob-Gyn, PA

Patient Information Consent Form

I have read and fully understand Laurel Ob-Gyn, PA’s Privacy Notification. I understand that Laurel Ob-Gyn, PA may use or disclose my person health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have to right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that Laurel Ob-Gyn, PA will consider requests for restrictions on a case-by-case basis, but does not have to agree to request for restrictions.

I have been given a copy of the short form for the “Notice of Patient Information Practices” and understand that I may obtain a copy of the complete version, which is posted in the lobby and hallways of Laurel Ob-Gyn, PA upon request.

I hereby consent to the use and disclosure of my personal health information for purposes as outlined in Laurel Ob-Gyn, PA’s Privacy Notice. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature of Patient or Parent/Guardian

Date

Designated Individuals Authorization

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Authorization For Treatment

I hereby consent to medical treatment, diagnostic procedures and injections by providers and staff of Laurel Ob-Gyn, PA. I understand diagnostic procedures may include, but are not limited to lab tests on blood, urine and tissue. I understand I may be asked to undergo diagnostic radiology procedures including but not limited to ultrasound. I understand I have the right to ask questions about my treatment and or procedures and I agree to notify my provider of my concerns.

I have read the above and agree to treatment to their content:

Patient Signature

Date