**OB-GYN ASSOCIATES OF OAK RIDGE, P.C.**
**PATIENT INFORMATION SHEET**
**PAYMENT IS DUE WHEN SERVICES ARE RENDERED(*INCLUDES CO-PAYS AND CO-INSURANCE)**

| PATIENT'S NAME- LAST | FIRST | MIDDLE | MAIDEN | MARITAL STATUS: S / M / W / D / SEP |
|---|---|---|---|---|

| AGE | BIRTHDATE | SOCIAL SECURITY # | LANGUAGE |
|---|---|---|---|

| ETHNICITY | HOME PHONE | CELL PHONE |
|---|---|---|

| STREET ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|

| POST OFFICE BOX | CITY | STATE | ZIP | EMAIL ADDRESS |
|---|---|---|---|---|

| PATIENTS EMPLOYER | OCCUPATION (INDICATE IF STUDENT) | HOW LONG EMPLOYED? | BUSINESS PHONE # |
|---|---|---|---|

| EMPLOYER'S STREET ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|

| SPOUSE OR PARENT'S NAME | BIRTHDATE | SOCIAL SECURITY # | PHONE # |
|---|---|---|---|

| SPOUSE OR PARENT'S ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|

| SPOUSE OR PARENTS EMPLOYER | OCCUPATION | HOW LONG EMPLOYED? | BUSINESS PHONE # |
|---|---|---|---|

| EMPLOYER'S STREET ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|

| FAMILY PHYSICIAN | PHONE # | FAMILY PHYSICIAN'S ADDRESS |
|---|---|---|

## INSURANCE INFORMATION

| PRIMARY INSURANCE | | SECONDARY INSURANCE | |
|---|---|---|---|
| INSURANCE NAME | | INSURANCE NAME | |
| SUBSCRIBER NUMBER | | SUBSCRIBER NUMBER | |
| GROUP NUMBER | EFFECTIVE DATES | GROUP NUMBER | EFFECTIVE DATES |
| SUBSCRIBER'S NAME | | SUBSCRIBER'S NAME | |
| SUBSCRIBER'S DOB | SUBSCRIBER'S SSN | SUBSCRIBER'S DOB | SUBSCRIBER'S SSN |
| PATIENT'S RELATIONSHIP TO THE SUBSCRIBER | | PATIENT'S RELATIONSHIP TO THE SUBSCRIBER | |

All Professional Services rendered are charged to the patient. Necessary forms will be completed to help expedite Insurance carrier payments. However, the Patient is responsible for all fees, regardless of insurance coverage. Payment is due for services when rendered unless other arrangements have been made in advance. I consent OBGYN and any other owner or servicer of my account contacting me about my account, including using any contact information or cell phone numbers I provide, and I consent to the use of any automatic telephone dialing system and/ or artificial or prerecorded voice when contacting me, even if I am charged for the call under my phone plan.

## INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE OB-GYN ASSOCIATES OF OAK RIDGE, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Signature: ______________________________________________ Date: ____________________

# OB-GYN Associates of Oak Ridge, P.C.

## FINANCIAL POLICY

Thank you for choosing us as your health care providers. We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. **We ask that you carefully read and sign the following financial policy.**

**** We require a copy of all insurance cards and ask that you present them at each visit.**

**** All new patients must complete our patient information forms AND our EMR (Digi Chart) on line registration before services are rendered.**

**** It is your responsibility to inform the practice of ANY or ALL pre-existing health conditions. Failure to do so may result in a denial from your insurance company. If this happens YOU are responsible for any outstanding balance.**

**** The forms of payment we accept are: Cash, Check, Visa, MasterCard and Discover.**

**Participating Insurances:** We participate with most insurance companies. Co-pays and/or deductibles are due at the time of service.

**Non-Participating Insurances:** Payment in full is required at the time of service.

**For All Insurances:** Please review your benefit listings summary. Well Woman or Annual Exams are usually considered as preventative care. This is often not covered by many insurance plans.

**For Medicare:** There is coverage for breast, pelvic exam and Pap smear – based on certain criteria. However, Medicare may not cover all of the Well Woman preventative exam.

**Obstetrical Patients:** After your visit to confirm your pregnancy, you will receive a letter along with financial information from our office detailing your insurance coverage and benefits to determine your financial obligation to us for your pregnancy care.

**Cancellation Policy:** If you must cancel or reschedule your appointment we would appreciate at least a 24 hour notice or you will be subjected to a $25 fee if proper notice is not given for cancelled or "no show" visits.

**Returned Checks:** There is a $30 fee on all returned checks.

I understand and agree that health insurance coverage is an agreement between an insurance carrier and me. I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amounts authorized be paid directly to this office. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I authorize OB-GYN Associates of Oak Ridge, P.C.to furnish information to insurance carriers concerning my illness and treatments. If delinquent account is turned over to our collection agency the patient is responsible for all associated collection fees, court cost, etc.

In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

| ______________________________ | ___________________________ | ____________________ |
|---|---|---|
| Patient's Signature | Patient's printed name | Date |
| ___________________________ | _________________________________ | ________________________ |
| Parent/ Guardian Signature | Parent/ Guardian Name | Patient name if Minor |

OBGYN ASSOCIATES OF OAK RIDGE, P.C.

I ________________________ give permission to the Physicians and their staff at OBGYN Associates of Oak Ridge to leave message regarding my care in the following manner when I am unavailable.

**Please mark all that apply:**

_____ May only leave information with myself **(please note that if you check here there should be no other choices checked)**
_____ May leave appointment reminders on my answering machine or voicemail
_____ May leave appointment reminders with_______________________________
_____ May leave lab results on my answering machine or voicemail
_____ May leave lab results with _________________________________________
_____ May leave general questions/information on my answering machine or voicemail
_____ May leave general questions/information with__________________________

I would prefer to be contacted at this number (______) _______ - ______________

## EMERGENCY CONTACT

In case of emergency, please list the names and contact information of whom we can contact below:

1. ______________________________________________________________
   Name Relation Number (including area code)
2. ______________________________________________________________
   Name Relation Number (including area code)

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT UNDER THE Health Insurance Portability Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certification. I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures on my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of HIPPA.

**Patient's name or legal guardian:** ______________________________________

**Signature:** ________________________________________**Date:** _______________