

South Baldwin Obstetrics & Gynecology, P.C.

Patient Name: _____
(Last) (First) (Middle) (Maiden)

Street Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(P.O. Box) (City) (State) (Zip)

Home Telephone: ____ - ____ - ____ Cell Phone: ____ - ____ - ____ Work Telephone: ____ - ____ - ____ Email: _____

DOB: ____/____/____ AGE: _____ SS#: ____ - ____ - ____ Patient Employer: _____

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Separated ____

Race: White ____ Black ____ Hispanic ____ Asian ____ Native American ____ Native Hawaiian ____

Primary Language: _____ Ethnicity: Hispanic ____ Non-Hispanic ____

Spouse Name: _____ Employer: _____ Work No. ____ - ____ - ____

Parent or Guardian (if patient is under 19): _____

Employer: _____ Work Telephone: ____ - ____ - ____

Person to contact in case of an emergency? _____ Relationship: _____ Phone: ____ - ____ - ____

INSURANCE INFORMATION Please present insurance card(s) & drivers license to receptionist for photocopying

INSURANCE COMPANY NAME POLICY HOLDERS NAME POLICY NUMBER

Primary _____

Secondary _____

Subscriber's Place of Employment _____ Date of Birth _____

- I consent to treatment as necessary or desirable to my care, included but not restricted to whatever drugs, medicine, performance of operations, and conduct of laboratory, or other studies that may be used by the doctor or qualified designate.
- I authorize the release of my medical information to treating or referring physicians and to insurance companies for payment.
- I agree this authorization will cover all medical services rendered until such authorization is revoked by me in writing.
- I authorize the use of a fax in order to submit medical information to pertinent parties.
- I agree that a photocopy of this form may be used in lieu of the original.
- If a claim should arise resulting from treatment provided pursuant to this consent from any action by the doctor or qualified designate, such claim shall be submitted to binding arbitration for a determination thereof.
- I also acknowledge full responsibility for the payment of services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless advance arrangements are made.
- I understand that I am financially responsible for any balance that is not covered by my insurance carrier after 60 days.
- IN CASE OF DEFAULT, I WILL BE RESPONSIBLE FOR ALL COSTS INCURRED IN THE COLLECTION OF THIS AND FUTURE OUTSTANDING BALANCES NOT TO EXCEED 50% OF THE UNPAID BALANCE.

COMMUNICATONS REGARDING MY ACCOUNTS

-Until my accounts are finally settled, I give direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

Signature Date Guardian Signature Date

From time to time, our doctors or staff may need to reach a patient directly concerning an appointment, test results, pathology reports, or medical information. It is at the patient's discretion when and with whom we share this information. This is due to HIPPA (Health Insurance Portability and Accountability Act of 1996).

I give SBOB/GYN, P.C., its employees and/or agents "express prior consent" to contact me at any/all phone #'s, including cell phone #'s, (by phone call or text message), for the purpose of treatment, insurance or payment.

I authorize South Baldwin Obstetrics & Gynecology physicians and staff to release information concerning me to whom I have listed below:

_____ Myself only

_____ My answering machine

_____ Those listed below

1. Name _____ Relationship _____ Phone _____

2. Name _____ Relationship _____ Phone _____

Patient Signature _____ Date _____

If you have completed this form, please select the option to PRINT it on the toolbar along the top of this window. Your data is not saved or transmitted. Use the button below if you would like to erase all of your answers above.