

# 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 \_\_\_\_\_