

Northlake OB/GYN
Patient Information Sheet

Last Name _____ First Name & Initial _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____

Home Phone _____ Cell Phone _____ Primary # _____

Marital Status (M / S / D / W) Patient Race _____ Religion _____

Patient E-Mail Address _____

Patient's Employer _____ Occupation _____

Employer's Address _____

City _____ State _____ Zip _____

Work Phone _____ Ext. _____

Primary Pharmacy Info:

Name: _____ addr: _____ ph # _____

How did you find us? (circle one) Internet Magazine Friend Physician - Dr. _____

Insurance Information

Primary Insurance Company _____

Member ID _____ Group # _____

Claims Mailing Address _____

Insurance Phone Number _____

Policy Holder Last Name _____ Policy Holder First Name _____

Policy Holder Date of Birth _____ Policy Holder SS# _____

Relationship to Patient _____

Policy Holder Employer _____

Employer Phone # _____

Signature

I certify that the above information is true and correct to the best of my knowledge.

Patient or Legal Guardian Birthdate: _____

_____ Date _____

Section I: Financial Agreement & Assignment of Benefits

In consideration for the services to be rendered to me, I hereby assume full responsibility to pay for those services in accordance with the rates now in effect at Northlake Obstetrics & Gynecology, P.A., to the extent that I am legally responsible for such payment. Payments that I am responsible for may include, but are not limited to, balance after insurance, non-covered services, and deductibles.

I hereby assign to Northlake Obstetrics & Gynecology, P.A., any and all benefits for services rendered under insurance policies, reimbursement, or pre-paid healthcare plans. I acknowledge any balance not covered or paid for by such policies is my legal responsibility. I understand that if my account is turned over to a collection agency, a 30% service charge will be added to the balance. I understand that I am required to inform Northlake Obstetrics & Gynecology, P.A., of any address, phone number, or insurance changes.

THIS IS A LEGAL FINANCIAL AGREEMENT OF BENEFITS FORM. BE SURE ANY QUESTIONS YOU MAY HAVE ARE ANSWERED BEFORE YOU SIGN AT THE BOTTOM OF THE PAGE.

Section II: Receipt Acknowledgement for the Notice of Privacy Practices

I, _____ have been made aware of the Notice of Privacy Practices for Northlake Obstetrics & Gynecology, P.A., I understand that this notice states how Northlake Obstetrics & Gynecology, P.A., may use and disclose my Protected Health Information (“PHI”).

I UNDERSTAND THAT A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST.

Section III: Medical Records Release and Forms

I understand that if I request a copy of my medical records to be sent to another doctor, I must allow 15 business days for processing from the time I submit a signed authorization. I understand that if I request my medical records to be released to me, I must pre-pay \$25 for in-house records or \$30 for records in storage and allow 15 business days for processing from the time I submit a signed authorization.

I understand if I submit a disability form, Family Medical Leave Act form, or any other form that requires a doctor signature and/or specific information to be completed, I will be charged \$15 and must allow 5 business days for processing.

I, _____ hereby authorize Northlake Obstetrics & Gynecology, P.A., to release any information, in the course of my treatment, necessary to process insurance claims and/or to any other requesting physician in reference to referrals or coordination of care.

Section IV: Release of Records to a Designated Third-Party

In addition to my treating physicians and medical facilities, I authorize Northlake Obstetrics & Gynecology, P.A., to release and discuss my medical/billing information and records to the following individuals. (This should include **friends or family members responsible for picking up your records when you are unable to do so.**) **PLEASE PRINT**

1. _____ Relationship: _____

1. _____ Relationship: _____

Patient Signature

By signing below I am verifying that I have read each of the four sections on this page. I understand each section and consent to and agree with the information stated in each section.

(Patient / Legal Representative Signature)

(Legal Representative’s Relationship To Patient)

(Date)