PATIENT INFORMATION

Patient's Legal Name: (Last) (First) (MI) ___________________________________

Preferred Full Name (if different from above): ___________________________

Address: ______________________________City, State, Zip: _______________________

Home Phone Number (landline):__________Cell: _________Work: ___________

E-Mail Address: ________________________ Date of Birth: _______________

Social Security Number: __________________ Gender Identity: ☐ Female ☐Male

Race: ☐American Indian/Alaska Native ☐Asian Native Hawaiian/Pacific Islander ☐Black/African American ☐White ☐Hispanic ☐Chose not to disclose ☐Other not listed _____________________

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

Name of *PRIMARY* Insurance Plan: ___________________________________

Policyholder: ___________________________ Subscriber ID#: ____________________

Group#:_________

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER_____________

Name of *SECONDARY* Insurance Plan: ____

Policyholder: ___________________________ Subscriber ID#: ____________________

Group#:_________

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER_____________

PHARMACY INFORMATION:

Name of Pharmacy:_____________________________ Phone Number:____________________

RESPONSIBLE PARTY INFORMATION (*If not self*)

(Information used for patient balance statements)

☐Check here if address and telephone information is same as patient

Responsible party name: (Last) (First) (MI) ___________________________________

Date of birth: MM /DD /YYYY ________________ Sex: ☐Female ☐Male

Responsible Party Social Security Number: ______________ Phone number: __________

Address: _______________________________ City, State: ZIP: _______________________

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) (First) ______________________________________

Phone number: _________________ Do you have a living will? ☐Yes ☐No

Emergency contact relationship to patient: ______________________

Guardian Address: ____________________ City, State: ZIP: _____________________

Home phone: ____________ Work phone:_______________ Ext. __________

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides Southern OBGYN with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.
You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: ________________________ Date: ___________

Printed name of patient or personal representative: __________________________

Relationship to patient: _____________________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. If you are concerned about the possibility of a violation, you may contact the U.S. Dept. of Health and Human Services, Office of Civil Rights.

OUR LEGAL DUTY: We are required by law to maintain the privacy of your health information and to give you this notice about our privacy practices, our legal duties and rights concerning this information. We reserve the right to change our privacy practices as permitted by law.

USES AND DISCLOSURES OF HEALTH INFORMATION: We may use and disclose health information about you for treatment, payment and healthcare operations.

TREATMENT: We may use or disclose your health information to a physician or other provider involved in your treatment.

PAYMENT: We may use or disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information for our healthcare operations. Healthcare operations are functions necessary to run and improve our operations. This may include billing audits, internal quality assurance, defense of legal matters and development of business plans.

BUSINESS ASSOCIATES: We may disclose your health information to our business associates who have entered into a business agreement with our office when this information is necessary for providing your care.

AS REQUIRED BY LAW: We may disclose your health information when we are required by law to do so.

YOUR AUTHORIZATION: You may give us written authorization to use, disclose your health information to anyone, and may revoke this authorization in writing.

TO YOUR, YOUR FAMILY AND FRIENDS: We may disclose information to anyone you permit, in writing, as listed on this form.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing without your written consent.

PERSON INVOLVED IN YOUR CARE: We will use our professional judgment to make reasonable inference in your best interest in allowing a person to pick up medical supplies or health forms on your behalf.

DISPLAY OF BABY PICTURE: We may display pictures of your baby which you personally have shared with our office.

APPOINTMENT REMINDERS: We may disclose your appointment information in the form of a reminder via answering machine

FAX TRANSMISSION: We may fax or receive faxed information to and from a third party involved in your healthcare.

PATIENT RIGHTS:

ACCESS: You have the right to view or get copies of your medical records with a written request. Copies will be made at a charge of $.50 per page up to 25 pages and $1.00 for each additional page thereafter.

RESTRICTIONS: You have the right to restrict our disclosure of your healthcare information in non-emergency situations.

ALTERNATIVE COMMUNICATION: You have the right to ask us to communicate with you in an alternative method or at an alternative address.

AMENDMENT: You have the right to request, in writing, that we amend your health information. We have the right to deny the request if we see fit.

DISCLOSURE ACCOUNTING: You have the right to request a loss of instance in which we disclosed your health information for purposes other than treatment within the past six years.

ADDITIONAL NOTICES: You have the right to obtain a copy of this notice.

SIGNING OF THIS DOCUMENT: You have the right to refuse to sign this acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read this notice.

PRINT NAME____**DATE**___________________

SIGNATURE____

PERSONS ALLOWED TO RECEIVE INFORMATION

NAME____RELATIONSHIP______________________________PHONE____________

NAME____RELATIONSHIP______________________________PHONE____________

SOUTHERN OBGYN

IMPORTANT INFORMATION
<u>PLEASE READ CAREFULLY, SIGN & DATE ALL AREAS</u>

All fees will be due at time of service, with the exception of pre-approved Medicare/Medicaid or private/third party insurance coverage. This office utilizes the latest technology in electronic claims processing for cost effective and accurate insurance reimbursement. As a service to you, we will file your claim(s) based upon the information provided, although, you are entirely responsible for any fees not reimbursed by the listed insurance coverage within a reasonable reimbursement period.

FINANCIAL AGREEMENT

I assume all responsibility for all obligations. I agree to pay all amounts for services rendered at time of service, or within 30 days of filing for insurance reimbursement. I further agree that in event it becomes necessary to place this account in the hands of a collection agency and/or attorney; I agree to pay any collection fee (33%) on the balance due and owing.

____ ______________________________

Patient's Signature *Date* *Witness*

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services, I hereby irrevocably assign and transfer to Southern OBGYN all rights, title, and interest in the benefits payable for services rendered by Southern OBGYN provided in the mentioned policies of insurance. Said assignment and transfer shall be for the recovery on said insurance policies, but shall not be considered to be an obligation of Southern OBGYN to pursue rights of recovery. I hereby authorize the insurance companies herein mentioned to pay Southern OBGYN all benefits due under said policies by reason of services rendered. I will pay Southern OBGYN all charges incurred. A Photostat copy of this authorization shall be considered valid and effective.

____ ______________________________

Patient's Signature *Date* *Witness*

STATE OF LOUISIANA MEDICARE/MEDICAID PROGRAM

MEDICARE/MEDICAID AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier which is any information needed for this or a related Medicare/Medicaid claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

NOTICE: Anyone who misrepresents or falsifies essential information to receive Federal funds requested by this form may, upon conviction be subject to fine or imprisonment under applicable Federal laws.

____ ______________________________

Patient's Signature *Date* *Witness*

AUTHORIZATION TO RELEASE INFORMATION AND FOR MEDICAL TREATMENT

AUTHORIZTION TO RELEASE MEDICAL INFORMATION: Southern OBGYN is authorized to release to or request from any insurance companies having coverage on me or referring physician or institution any of my medical records pertaining to any injury or illness. A Photostat copy of this authorization shall be considered valid and effective; I also, hereby, authorize Southern OBGYN to treat me for any illness related to my health and well-being, either at his office or in the hospital. This authorization is valid until revoked by me in writing.

____ ______________________________

Patient's Signature Date Witness