

Brunswick-Hills Obstetrics & Gynecology

ALL ITEMS MUST BE COMPLETED. PLEASE PRESENT YOUR INSURANCE CARDS TO THE FRONT DESK

LAST NAME		FIRST NAME		MAIDEN NAME		BIRTHDATE / /		AGE	
MARITAL STATUS S M WID DIV SEP		SOC. SECURITY #		DRIVERS LICENSE #		HOME TELEPHONE		CELL PHONE #	
ADDRESS				CITY		STATE		ZIP	
YOUR E-MAIL ADDRESS						PERMISSION TO EMAIL YOU: YES NO			
EMPLOYER NAME				EMPLOYER ADDRESS & CITY				EMPLOYER PHONE #:	
REFERRED BY:		EMERGENCY NAME & PHONE # OF FRIEND OR RELATIVE NOT LIVING WITH YOU:				ARE YOU IN THE MILITARY? YES NO			
SPOUSE/PARTNER NAME:				SPOUSE/PARTNER EMPLOYER					

1) PRIMARY INSURANCE COMPANY NAME		INSURANCE COMPANY ADDRESS:							
INSURANCE POLICY ID #:		INSURANCE GROUP #		EFFECTIVE DATE		IS INSURANCE THROUGH SUBSCRIBER'S EMPLOYER? YES NO			
NAME OF SUBSCRIBER		SUBSCRIBER SS #:		SUBSCRIBER'S BIRTH DATE		RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DAUGHTER OTHER			
SUBSCRIBER'S EMPLOYER				EMPLOYER'S ADDRESS					
2) SECONDARY INSURANCE COMPANY NAME		INSURANCE COMPANY ADDRESS:							
INSURANCE POLICY ID #:		INSURANCE GROUP #				IS INSURANCE THROUGH SUBSCRIBER'S EMPLOYER? YES NO			
NAME OF SUBSCRIBER		SUBSCRIBER SS #:		SUBSCRIBER'S BIRTH DATE		RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DAUGHTER OTHER			
SUBSCRIBER'S EMPLOYER				EMPLOYER'S ADDRESS					

PATIENT CONFIDENTIALITY - IT IS OUR POLICY TO CALL YOU TO CONFIRM YOUR SCHEDULED APPOINTMENT AND/OR PROCEDURE, AND TO REPORT TEST RESULTS. DUE TO THE PRIVACY RULE, WE CAN ONLY RELEASE INFORMATION TO THOSE YOU LIST BELOW.

NAME	RELATIONSHIP	TELEPHONE #

ARE WE ABLE TO LEAVE A MESSAGE/TEST RESULTS ON YOUR ANSWERING MACHINE _____ YES _____ NO

ARE YOU ABLE TO RECEIVE CALLS AT YOUR PLACE OF BUSINESS? _____ YES _____ NO

IF YES, CAN WE STATE WHO AND FROM WHERE WE ARE CALLING? _____ YES _____ NO

DO WE HAVE PERMISSION TO RELEASE HEALTH INFORMATION TO OTHER PROVIDERS IN CHARGE OF YOUR HEALTHCARE? _____ YES _____ NO

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. THE PATIENT IS RESPONSIBLE FOR FURNISHING OUR OFFICE WITH ALL INFORMATION REQUESTED ABOVE. THE PATIENT IS ALSO RESPONSIBLE FOR FURNISHING ANY NECESSARY INSURANCE FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION OR SURGICAL PROCEDURES.

INSURANCE AUTHORIZATION & ASSIGNMENT, & PAYMENT RESPONSIBILITY - I HEREBY AUTHORIZE BRUNSWICK-HILLS OB/GYN TO FURNISH INFORMATION TO ANY AND ALL INSURANCE CARRIERS CONCERNING MY MEDICAL RECORDS AND TREATMENTS; AND GIVE AUTHORIZATION FOR THE OFFICE TO REQUEST A REDETERMINATION ON MY BEHALF FOR THE ANY SERVICES RENDERED FOR ASSIGNED AND NON-ASSIGNED CLAIMS. I HEREBY ASSIGN TO THE PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS. I ACKNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND ALL THE CHARGES INCURRED FROM THOSE SERVICES. ALTHOUGH I HAVE REQUESTED THE PRACTITIONER TO BILL MY INSURANCE COMPANY ON MY BEHALF, I CLEARLY UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE FOR ANY REASON. I WILL ALSO BE RESPONSIBLE FOR ANY CO-PAYS, CO-INSURANCE AMOUNTS, AND DEDUCTIBLES. ANY PAYMENTS MADE DIRECTLY TO THE PATIENT AND OWING TO THE PHYSICIANS WILL BE REMITTED IMMEDIATELY, PAYABLE TO BRUNSWICK-HILLS OB/GYN. IF THERE IS A DEFAULT IN ANY ONE PAYMENT (NO PAYMENT WHEN DUE) THERE WILL BE AN ADDED 25% COLLECTION OR ATTORNEYS' FEE IF YOUR ACCOUNT GOES TO A COLLECTION AGENCY. IN ADDITION, INTEREST AT 1.5% OR \$5.00 SURCHARGE WILL BE CHARGED MONTHLY TO THE TOTAL OUTSTANDING BALANCE OVER 60 DAYS OLD.

PLEASE SIGN ONLY "ONCE" PER VISIT

SIGNATURE: _____ DATE: _____

SIGNATURE: _____ DATE: _____

SIGNATURE: _____ DATE: _____