GENESIS OB/GYN

Patient Name: _____DOB:_____SSN#:_____

Single_____ Married _____ Divorced_____ Widowed_____

Mailing Address: _____City: _____ State: _____ Zip: _____

Preferred Contact Number: _____ Home Cell Work

Preferred Pharmacy/location: _____

If patient is a Minor - Please complete the section:

Parent/Guardian: _____Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Person to contact in case of emergency (not living with you):

Name: _____ Relationship: _____ Phone: _____

I authorize Genesis Ob/Gyn and clinical staff to release any medical or billing information necessary for treatment, payment or healthcare operations to the following family and/or friends:

IF YOU DO NOT LIST ANYONE, WE CANNOT SPEAK TO ANYONE REGARDING YOUR MEDICAL CARE

NAME:	RELATIONSHIP:
_____	_____
_____	_____
_____	_____
_____	_____

I UNDERSTAND THAT BY LISTING FAMILY OR FRIENDS TO THE ABOVE LIST ENABLES THE PHYSICIAN AND STAFF TO RELEASE PROTECTED HEALTH CARE INFORMATION AND BILLING INFORMATION TO THAT PERSON.

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

Our office utilizes a healthcare patient portal. You will receive lab results and be able to send messages to the nursing staff and providers in a secure, protected platform. We must have your email address to create your portal access. NOTE: This request will remain in effect until you notify us of a change.

Email Address (to access patient portal): _____

GENESIS OB/GYN

AUTHORIZATION FOR CARE

I grant permission to the employees of this clinic to render routine outpatient care to me and to carry out the orders of the clinic physician.

INSURANCE COVERAGE AND ASSIGNMENT OF BENEFITS

Medicare Benefits: As a medicare patient, I certify that the information given by me apply for payment under Title XVII of the Social Security Act is correct. I request payment of authorized benefits be made on my behalf.

Other Insurance: I hereby authorize and transfer to Genesis Ob/Gyn any commercial, supplement or Medigap insurance or Medicaid benefit payable to or for my benefit for the payment of such services rendered. I have reported to the Clinic a complete listing of my additional coverage: I understand that the Clinic will not file a claim for any insurance not reported before services are rendered.

FINANCIAL RESPONSIBILITY

I understand that regardless of any assigned insurance benefits, I am responsible for the total allowable charge for services rendered. I understand that any amount remaining on this account after applicable insurance have been filed and settled, will be paid upon notice of a balance due to Genesis Ob/Gyn. I understand that it is my responsibility to notify the Front Desk staff of any insurance or address change.

RELEASE OF INFORMATION

I authorized this clinic to release any medical information pertaining to my diagnosis and treatment at this clinic to: (1) representatives of local, state or federal agencies in accordance with the law; (2) Medicare (3) Medicaid (4) my insurance company representatives; or (5) any person or entities financially responsible for my care. I further authorize release of this information to health care providers associated with my care outside the clinic to facilitate health care.

I request the above acknowledgement to be in effect for one year from the date of this document for the clinic services rendered at this location. I the undersigned have read or had read to me the above and do hereby accept and agree to the terms stated above.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Staff Member Witness Date