GENESIS OB/GYN

Today's Date: _____

Referred by: _____ Primary Care Physician: _____

Patient Name: _____DOB:_____SSN#:_____

Single_____ Married _____ Divorced_____ Widowed_____

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

Preferred Contact Number: _____ Home Cell Work

Preferred Pharmacy and location: _____

If Minor - Please complete

Parent/Guardian: _____Relationship to patient: _____

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

Employment:

Patient Employer: _____ Dept: _____

Employer Phone: _____ Ext: _____

Spouse Information:

Spouse's Name: _____ DOB: _____ SSN#: _____

Spouse's Employer: _____ Dept: _____

Work Phone: _____ Cell Phone: _____

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

Name: _____ Relationship: _____ Phone: _____

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

INSURANCE INFORMATION

Insurance Coverage: Yes____ No____ Cash Pay Medicaid Medicare

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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 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

_____ _____

Witness Date

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FINANCIAL AGREEMENT

1. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance coverage if proper information is received. At the time of your visit, you are required to pay your co-payments, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company. For unpaid claims over 45 days, it is your responsibility to follow up with your insurance carrier, and the balance due is considered payable.
2. It is your responsibility to notify our front desk staff of any insurance or address changes.
3. You will be responsible for any charges that occur if we are not notified of any insurances or address changes.
4. Any cost incurred to collect a debt will be at the expense of the patient/responsible party.

PATIENT AUTHORIZATION

I authorize Genesis Ob/Gyn and/or the billing service to submit insurance using my signature on file below.
I authorize release of any medical information necessary in order to process this assignment of the claim.
I authorize payment of medical benefits to be paid directly to Genesis Ob/Gyn for services described on the claim form submitted to the insurance company.

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.

Signature: _____Date: _____

Printed Name: _____ Relation if minor: _____

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PATIENT AUTHORIZATION FOR ELECTRONIC PRESCRIBING

This office uses an electronic prescription system which allows prescriptions and related information to be electronically sent between L. Justin Gayle, M.D., Jamie Bouchard, N.P. and your pharmacy. I have been made aware and understand that this office uses and electronic prescription system. I have been informed and understand that my provider is using an electronic prescribing system and will be able to see information about medication I am already taking, including those prescribed by other providers. I give my consent to L. Justin Gayle, M.D./Jamie Bouchard, N.P. to use electronic prescribing on my behalf and to see this protected health information.

Signature: _____ Date: _____

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

I request communication of my protected health information by the following means and at the following locations. I understand this request applies only to communications from the office of Genesis Ob/Gyn to the patient and communication that would be sent to the name of the insured of the insurance policy that covers the patient as a dependent of the named insured.

Please indicated the methods and/or locations by or at which we may contact you:

Telephone Number: _____

Mailing Address: _____

Email Address (to access patient portal): _____

NOTE: This request will remain in effect until you notify us of a change.

Signature: _____ Date: _____

Relationship (for minor patient): _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have read and reviewed the PRIVACY NOTICE of Genesis Ob/Gyn.

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____

Relationship (for minor patient): _____