Obstetrics and Gynecology Care Associates, S.C.
1505 Eastland Dr. Suite 500 ● Bloomington, IL 61701
309-662-CARE (2273) ● Fax: 309-662-2014
www.obgyncare.com

PATIENT INFORMATION Date Completed_____

Preferred Pharmacy_____ Pharmacy Location _____

Preferred Hospital or Surgical Facility _____

Name_____
Last Name First Name M.I. Preferred Name Maiden Name

Address_____
Street City and State Zip Code

Home_____Work_____ Cell _____

Preferred Phone: ☐HM ☐WK ☐CELL Emergency Contact:_____ Emergency Phone:_____

Birth Date_____ Age _____ Marital Status __S __M __W __D SS#_____-_____-_____

Race: ___American Indian / Alaskan Native ___Asian ___Black / African American
___Natural Hawaiian / Pacific Islander___White ___ Other Race ___ Unknown ___ Decline

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Unknown ___Decline

Preferred Method of Communication for Appointment and Yearly Reminders: ___Phone ___E-mail ___Text

E-mail: _____

Employed by: _____ Occupation: _____

Spouse's Name:_____

Spouse's Employer: _____ Spouse's Work Phone:_____

How did you hear about us? ___Friend ___Family Member ___Co-Worker ___Radio ___Web Site ___ Print Ad
___ Publication / Article ___Health Fair ___Doctor / ER ___Seize the Deal ___Yellow Pages

Doctor Referral:_____

If patient is a minor, please complete this section:

Guarantor Name: _____
Last Name First Name M.I.

Address _____
Street City and State Zip Code

Guarantor Birth Date _____ Home Phone Number _____

Work Phone Number _____ Relationship to Patient_____

PRIMARY INSURANCE COVERAGE

Name of Policy Holder_____

Patient Relationship to Policy Holder _____

Insurance Company_____

Policy Holder's Date of Birth_____

Policy Holder's SS#_____

SECONDARY INSURANCE COVERAGE

Name of Policy Holder_____

Patient Relationship to Policy Holder _____

Insurance Company_____

Policy Holder's Date of Birth_____

Policy Holder's SS#_____

CONSENT TO TREAT

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form, obtain medication history, and to fulfill the orders of the physicians; including consultants, associates and assistants of the physician's choice. Our office follows the standards of care recommended by the American College of Obstetricians and Gynecologists (ACOG) and the Center for Disease Control (CDC). _____ Initials

HIPAA AUTHORIZATION

I hereby authorize employees and agents; including physicians and physician assistants of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates and assistants of the physician's choice.

For further explanation or for a copy of our HIPAA Privacy Notice please see the front desk staff or visit our website. This release is effective until revoked by patient with written signature.

Please mark appropriate section below:

____ No Restrictions ____ Restrictions: (Please list your requested restrictions)

_____

_____

If there is anyone you would allow us to share information with, please list the names and relationships of those people below.

____ May share my protected health and financial information with:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Initials

FINANCIAL AGREEMENT

- It is your responsibility to inform our office of any address, telephone number or insurance changes. You may be responsible for additional charges if your primary insurance is terminated during your medical care.
- Your account is to be kept current - accordingly, all self-pay or insurance co-payments, co-insurances, and deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard, or Discover
- If you do not have your payment(s), your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for your original appointment.
- A returned check will result in a $25 service charge ***and*** all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $5.
- Refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims.
- Any unpaid balances older than 30 days may be subject to 2% interest per month.
- If your account is assigned to a collection agency, you will be responsible for any costs incurred in collection of said balance, which will include collection agency fees of 30% , court costs and attorney fees and will not be able to schedule further appointments.

We will submit your insurance claims. However, ***we must emphasize that as medical providers, our relationship is with you <u>not</u> your insurance company.*** We attempt to verify your benefits. Please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

- Not all services are a covered benefit with all insurance plans
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility.
- We realize that temporary financial problems may affect timely payment. We urge you to contact us promptly for assistance.

I authorize OB/GYN Care Associates, S.C. to release to my insurance carrier and its agents any information needed to determine the benefits payable under their coverage. I authorize my insurance company and its carriers to disclose any information requested regarding claims for medical benefits. A copy of this authorization may be used in place of the original. I request that payment of authorized medical benefits be made on my behalf to OB/GYN Care Associates, S.C. for services furnished to me.

Initials

Your signature below indicates that you understand and agree to the above.

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____

We look forward to providing you with the highest quality care and trust. We hope you will find us friendly and helpful. You may receive a patient satisfaction survey and we would appreciate it, if you could take a few minutes to let us know how we are doing. You may also visit our website and complete a survey online.