PATIENT REGISTRATION

Health ONE Consultants in Obstetrics and Gynecology
Physician Care℠

Date: _____Patient First Name: _____ MI_____ Last Name: _____

Mailing Address: _____ Apt/Unit #:_____

City: _____ State: _____ Zip: _____

Primary phone □cell □home: _____ Secondary phone □cell □ home: _____

SSN: _____ Date of Birth: _____ Marital Status: M S D W

Sex: Female Male Employer's Name: _____ Work Phone: _____

Student Status: □ Full-Time Student □ Part-Time Student

Patients Email Address:_____Web enable: Y or N

(For our patient satisfaction surveys/patient web portal)

Race: _____ Ethnicity: _____ Language: _____

Emergency Contact Name: _____ Phone Number: _____

Relationship:_____

How did you hear about us?

□ Referring Physician's Name _____ □ Twitter □ Yelp.com

□ Family/Friends □ Facebook □ Vitals.com

□ Search Engine (e.g. Google, Bing, Yahoo) □ Insurance □ Website: consobgyn.com □ Healthgrades.com

□ ZocDoc □ Other _____

Health Insurance Information (ALL FIELDS ARE REQUIRED)

WE WILL COPY ORIGINAL CARD AT YOUR APPOINTMENT IN THE OFFICE

Primary Insurance Name: _____

Policy Holder Name: _____ **Relationship to patient**: _____

Birthdate of Policy Holder: _____

Secondary Insurance Name: _____

Policy Holder Name: _____ **Relationship to patient**: _____

Birthdate of Policy Holder: _____

PHONE MESSAGE CONSENT

Health ONE Consultants in Obstetrics and Gynecology
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Your provider will at times need to contact you. By filling out the information below, we will be better able to serve you.

Name: _____

In an effort to protect your privacy, we have developed a policy on leaving medical care messages:

- We will **not** leave messages with anyone except the patient or legal guardian.
- We will **not** leave any confidential information on an answering machine.
- We will **not** leave any message in a voice mail.
  UNLESSWE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I, _____, give HealthONE my permission to leave a

Detailed or General (please circle one) message regarding my medical care, future appointments, test results, personal information and/or billing and/or speak with the following. I fully understand that this consent will remain valid until revoked in writing.

My **Home** answering machine: # _____ Initials: _____

My **Cell** voice mail: # _____ Initials: _____

My **Office/Work** voice mail: # _____ Initials: _____

Other Contacts:

Contact Name: _____ Relationship: _____

Phone #: _____ Initials: _____

Contact Name: _____ Relationship: _____

Phone #: _____ Initials: _____

Signature: _____ Date: _____

Date of Birth _____

FINANCIAL POLICY

Health ONE Consultants in Obstetrics and Gynecology
Physician Care℠

Thank you for choosing Consultants in Ob/Gyn for your healthcare. In order to achieve our goal of providing and maintain a good physician-patient relationship we believe it is important to have a solid financial policy in place. We also believe that these policies will allow us to provide our patients with high quality, cost-effective care. We ask that you carefully read and sign the following Consultants Financial Policy prior to your treatment.

1. Upon arrival, please sign in at the front desk and present your current health insurance card as well as your driver's license or another acceptable form of ID. You will be asked to present both of these items at each visit for proper identification.
2. If you do not have health insurance coverage, or we do not participate with your insurance plan you will be given a 35% discount. Acceptable forms of payment are cash, check or credit card.
3. You are responsible to have complete insurance information available for Consultants so that we may accurately file your claims. Complete insurance information includes current benefit cards (primary and secondary), and proper identification.
4. You are responsible for checking with your insurance plan regarding any co-payments, deductible or co-insurance that you may owe at the time of service.
5. Co-payments are a contractual obligation with your insurance company. You are required to pay you co-payment, and we are required to collect your co-payment at the time of each visit. Co-payments are collected prior to service.
6. If the insurance information that you provide at the time of your visist is incorrect, you will be responsible for payment of your visit and to submit the charges to the correct plan.
7. For indemnity-type health insurance plans, insurance payments received by Consultants will be applied to your account and you agree to pay the balance.
8. If you have HMO or PPO health insurance plan and our physicians participate in your health insurance plan, we will accept payment from the carrier for services covered by your benefit plan.
9. If you undergo a surgical procedure, in addition to a bill from your surgeon you may also receive bills from the hospital where the procedure is performed, anesthesia, pathology/lab, radiology and various consultants.
10. Not all services provided by our office are covered by every health insurance plan. Any service determined NOT to be covered by your plan will be your responsibility.
11. Consultants is committed to providing the best treatment for our patients; however you are responsible for any unpaid balance regardless of your insurance company's arbitrary determination of usual and customary rates.

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IT IS YOUR RESPONSIBILITY TO KNOW YOUR HEALTHCARE BENEFITS AND COVERAGE LIMITATIONS.

We will be happy to address any questions you may have after reading our Financial Policy. Please let our staff know if you would like a copy of this policy.

I have read and understand Consultants in Ob/Gyn's Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in the above policy. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any change to my health insurance coverage.

Patient's Printed Name _____ Date _____

Patient's Signature _____ Date of Birth _____

Legal Guardian Printed Name _____ Relationship to Patient _____

Legal Guardian Signature _____ Date _____