McDowell Mountain Gynecology

Patient Information

Patient Last Name: _____ First Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Social Security No.: _____

Marital Status: **S M W D** Drivers License State & No.: _____

EMERGENCY CONTACT NAME, PHONE NO. AND RELATIONSHIP

_____

Referred by: _____ Pharmacy # and Location _____

HIPPA

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time by informing the Privacy Officer in writing.

Home Telephone No.: May we leave a message with a callback number or appointment reminder on voicemail. **YES** **NO**

Work Telephone No.: May we leave a message with a callback number or appointment reminder on voicemail. **YES** **NO**

Cell Telephone No.: May we leave a message with a callback number or appointment reminder on voicemail. **YES** **NO**

Written Communication: May we send you an e-mail. **YES** **NO**

To whom can we release information:

_____ _____

Name **Relationship**

INSURANCE INFORMATIONS (Please provide insurance card and Drivers License for us to copy)

Insurance Company: _____ Policy Holder: _____

Policy Holder Date of Birth: _____ Social Security No.: _____

Policy No or ID: _____ Group No.: _____

Insurance Disclaimer

As a courtesy, we will submit your claim for all services to your insurance company. Please remember your individual health insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Be aware that some of our services my not be covered by your insurances policy. By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance; we will not alter your claim, change diagnosis, or report a different service than what was performed in order to have your insurance cover the charges. It is your responsibility to know your insurance policy. Your will be responsible for all balances.

CONSENT FOR TREATMENT/INSURANCE AUTHORIZATION AND ASSIGNMENT

I or my representative, recognizing the need for care, consent to all and any services as ordered by my physician, including, but not limited to, laboratory test, medical or surgical treatment, examination, and other services rendered under the specific instructions of my physician. I authorize and request that payments under my medical insurance programs be made directly to the above provider for any services furnished to me. I also authorize the provider to release any information needed for payment of claims. If further permit copies of this authorization to be used in place of the original.

_____ _____

Patient or Responsible Party Signature Date