OB/GYN HEALTH CENTER
REGISTRATION FORM

(Please Print)

Today's date:_____

PATIENT INFORMATION					
Patients Name: (last --- first --- middle initial)			Preferred Name:		☐ Female ☐ Male
Birth date:	Age:	Social Security:			
Street address:			City:	State	Zip Code:
Cell Phone:	Home Phone:		Email:		
Employer:	Employer Phone Number:		Occupation:		
Pharmacy:		Pharmacy Phone Number / Address:			
Previous GYN: (In the Last 3 Years) _____ First Name _____ Last Name Phone #:		Primary Care/ Family Doctor: _____ First Name _____ Last Name Phone #:			

INSURANCE INFORMATION	
Relationship to patient: ☐self ☐spouse ☐parent ☐guardian	
Insurance Company Name:	Member ID #:
Group Number:	Phone Number:
Name of Policy Holder:	Date of Birth of Policy Holder:

IN CASE OF EMERGENCY		
Name:	Relationship to patient:	Phone Number:

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all of my collection and attorney fees.

Patient/Guardian signature:	Date:

OB-GYN HEALTH CENTER
Office Policies & Consent
****Initial after each Policy & Consent****

1. **Insurance Benefits:** Payment is expected at the time of service. This includes copays, co-insurance, and any remaining deductibles. **Please note**, all benefit information is provided to us by your insurance company. If there are any discrepancies with your benefits, we ask that **you** contact your insurance company. _____ **Initial**

2. **Financial Responsibility:** Upon checking in, our staff will inform you of your financial obligation for your appointment as well as any past due balances. Payment at that time will be requested. _____ **Initial**

3. **Delinquent Accounts:** Our office makes reasonable financial arrangements with our patients. These arrangements must be made with our billing/insurance department. If you have not made a financial arrangement and/or have not made an attempt to pay your obligation, your account will be placed in a collection status. Your account will be turned over by the practice to a debt collector. A fee in the amount of **35% of the total amount due**, will be added to your outstanding balance. _____ **Initial**

4. **No Show Policy:** Our office enforces a "No Show" policy. We ask that if you must cancel your appointment that you kindly give us a 24-hour notice. **New Patient appointment** "No Show" fee is **$50.00**. **Established Patient appointments** "No Show" fee is **$25.00**. The "No Show" fee is required to be paid before another appointment can be schedule. _____ **Initial**

5. **Surgical Fees:** At the time your procedure/surgery is scheduled our office will notify you your estimated financial obligation. Your obligation is expected to be paid no later than your pre-op visit. Failure to pay your portion may result in your procedure/surgery being reschedule. _____ **Initial**

6. **Insurance Processing:** Our office will file primary insurance plans ONLY. If you are submitting your own claim you will be given the information needed when you check out to forward to your insurance company. _____ **Initial**

7. **Medical Records:** There is a $1.00 per page for the first 25 pages, and $0.25 for each additional page. Allow 72 hours for your request to be fulfilled. Medical Record request can be printed from our website; ***obgynhealthcenter.org*** _____ **Initial**

8. **Completion of All Forms**: There is $10.00 Administration fee for each form. The fee is to be paid prior to completion of forms. ***Example: FMLA, Disability, etc.*** _____ **Initial**

9. ***Consent:*** I hereby consent to a medically indicated physical examination. This may include but is not limited to a pelvic examination. This consent will remain active until I withdraw my consent in writing. _____ **Initial**

I certify that I have read and understand the above office policies & Consent

_____ _____

Patient/Guardian Signature Date

_____ _____

Patient/Guardian Printed Name Patient DOB

Notice of Privacy Acknowledgement

OB-GYN Health Center of Volusia, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ ***Attempt:*** _____

Staff Name: _____

noticeprivack

Authorization to Discuss Patients Medical Information

OB-GYN HEALTH CENTER

Christine DaSilva, MD ~ John Meyers, MD ~ Cynthia Baldwin, MD
Stacey McKinnon, APRN ~ Kayla Norwood, APRN
769 N. Clyde Morris Blvd
Daytona Beach, FL 32114
386-258-0123

Date: _____

I,_____give the **OB-GYN Health Center** permission to discuss my medical information with:

_____ _____
Name (Print) Relationship

_____ _____
Name (Print) Relationship

I understand that this Authorization to discuss my Medical Information expires twelve (12) months from the date of my signature.

_____
Expiration Date: Month/Day/Year

_____ _____ _____
Patient Name Patient Signature Date

_____ _____
Witness Date

Y:authdiscusspt
REV 01/23