Date: _____

Dr. _____

Mobile Ob-Gyn

Patient ID: _____
Other ID: _____
office use only

New Patient Form

Please fill out all necessary information

Patient Information

Last Name _____

First Name _____

Middle _____

Preferred/Nickname _____

Maiden Name _____

Prefix
Ms. Mrs. Miss

DOB _____

SSN # _____-____-_____

Marital Status _____

Race _____

Ethnicity _____

Address Information

Address _____

Apt # _____

City/State/Zip _____

Contact Information

Home Phone _____

Cell _____

Email _____

Insurance Information

Primary Insurance _____

Policy Number _____

Group Number _____

Insured _____

Relationship to Patient _____

SSN # _____-____-_____

Address _____

City / State / ZIP _____

DOB _____

Secondary Insurance _____

Policy Number _____

Group Number _____

Insured _____

Relationship to Patient _____

SSN # _____-____-_____

Address _____

City / State / ZIP _____

DOB _____

Emergency Contact

Relationship _____

Phone # _____

Primary Care Physician/Referring Physician

_____

I give permission to Mobile Ob-Gyn, P.C. to administer treatment and perform necessary minor operative procedures in diagnosing and treating my condition. By signing this form, I am granting consent to Mobile Ob-Gyn, P.C. to use and disclosed protected health information for the purposes of treatment, payment and health care operations. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full. You have the right to request us to restrict how we use and disclose your protected health information. We are not required by law to grant your request, but if we do, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.

I accept full responsibility for payment. In case of default I will be responsible for all costs incurred in the collection of any outstanding balances, not to exceed 50% of the unpaid balances.

_____ _____

Signature **Date**

Mobile Ob-Gyn

Patient Agreement / Authorization Form

TREATMENT CONSENT, PAYMENT POLICY, & COMMUNICATION CONSENT

I give my permission to Mobile Ob-Gyn, P.C. to administer treatment and perform necessary minor operative procedures in diagnosing and treating my condition.

Our policy is to require payment at the time services are provided. For convenience, we accept cash, Visa, Mastercard, and personal check. We also accept certain insurance plans upon verification of benefits and coverage. Claims are filed on such plans as a convenience to our patients; it is the patient's responsibility to pay deductibles, co-pays, and non-covered amounts at the time of the office visit.

If you are a private pay patient, our entire fee schedule can be found on our website at www.mobileobgyn.com under the "patient info" tab.

I agree to be personally and fully responsible for payment. In case of default, I accept the fee charges as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees of 33.33%, attorney fees, and/or court costs if such are necessary. I waive now and forever my right of exemption under the laws of the Constitution of the State of Alabama and any other state.

We attempt to remain informed about our patient's insurance plans; however, due to the enormous number of plans, it is impossible for us to determine the exact benefits which each individual plan might pay. Therefore, we rely on the patient to be knowledgeable about their insurance plan and the coverage and benefits it provides. **Please note: by filing a claim with insurance, we do not guarantee the insurance coverage or benefits paid, nor can we accept responsibility for any amounts which the insurance company may not pay. Written or verbal estimates given by our office are not a guarantee of payment. Amounts filed with insurance are the patient's responsibility; if for any reason a claim is not fully paid by insurance, the remaining unpaid balance will become due from the patient and payable at that time.** Generally, we allow 45 days for claims to be paid by an insurance company.

If the patient has more than one insurance policy we must be informed of and file with **all of them at the time of service,** regardless of coverage or lack thereof for the type of care being provided. We must file a claim with each and all of the patient's health insurance policies. If we file on an insurance policy that we believe to be primary and they pay for the office visit, the insurance company will ten recoup the money they have paid on the claim upon learning that the patient has another insurance. In some cases, we only have 90 days to file a claim. If we have not been provided with the correct insurance information and the 90 days have lapsed, the primary insurance will not pay and will result in the secondary not paying the claim, either. **Failure to report all insurance information will result in the patient being liable for all applicable charges.**

If you do not understand this, please ask to speak to one of our insurance professionals and they will gladly explain in more detail.

I agree to let Mobile Ob-Gyn, P.C. and/or agents to contact me by telephone at any telephone number associated with my account, including wireless telephone numbers. I may also be contacted by text message or e-mail, using any e-mail address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing services.

I have read and understand the Payment Policy, Treatment Consent, and Communication Consent of Mobile Ob-Gyn, P.C.

_____ _____

Signature of Patient Date

6701 Airport Blvd. Suite B-321 Mobile, AL 36608 (251) 633-0793 fax (251) 633-0736

MOBILE OB-GYN, P.C.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT, HEALTH CARE OPERATIONS, AND PAYMENT

I, _____, understand that as part of my health care, Mobile Ob-Gyn, P.C. maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatments, and any plans for future care or treatment.

I understand and have been provided with access to Mobile Ob-Gyn, P.C.'s **Notice of Privacy Practices** and **Individual Rights** for Protected Health Information which provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice before signing this authorization. I understand that the practice reserves the right to change its Notice of Privacy Practices prior to implementation. Copies will be available at Mobile Ob-Gyn, P.C. I understand that I have the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I also understand that I may revoke this authorization in writing at any time, except in the circumstances in which information has already been disclosed.

I acknowledge that I have been provided with access to the **Notice of Privacy Practices** and **Individual Rights**.

I understand and accept the terms as stated.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Representative Relationship

6701 Airport Blvd. Suite B-321 Mobile, AL 36608 (251) 633-0793 fax (251) 633-0736

MOBILE OB-GYN, P.C.

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: ___/___/_____

SSN: _____-____-_____

It is occasionally necessary for representatives of Mobile Ob-Gyn, P.C. to contact patients for various purposes. These communications may range from appointment reminders to prescription notifications, or to discuss lab or test results. At no time will a representative of Mobile Ob-Gyn, P.C. discuss your medical circumstances or condition without your consent. The purpose of this consent is to authorize Mobile Ob-Gyn, P.C. to leave messages with members of your household, on your answering machine/voicemail, patient portal, or other types of communication that you consent to below.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Please initial below to authorize us to contact you utilizing the following:

_____ I authorize Mobile Ob-Gyn, P.C. to leave messages on my answering machine and/or voicemail using the contact number(s) I have provided.

_____ I authorize Mobile Ob-Gyn, P.C. to leave messages with household members at the contact number(s) I have provided.

_____ I authorize Mobile Ob-Gyn, P.C. to contact me using the email address I have provided.

_____ I authorize Mobile Ob-Gyn, P.C. to contact my listed emergency contact.

If you wish us to discuss your health information with someone other than you (test results, medical records, etc.) please list that individual, their relationship to you, and contact number.

Name: _____ Relationship: _____ Number: _____

Name: _____ Relationship: _____ Number: _____

Name: _____ Relationship: _____ Number: _____

_____ _____

Patient or Personal Representative Signature Date

6701 Airport Blvd. Suite B-321 Mobile, AL 36608 (251) 633-0793 fax (251) 633-0736

MOBILE OB-GYN, P.C.