Contemporary Obstetrics & Gynecology, P.C

Patient Registration Form
(All bolded fields are required)

Legal Name: _____Date: _____ **Gender**:_____

Preferred Name: _____ **Date of Birth**: _____ SSN: _____

Address: _____**APT#**_____**City, State, Zip** _____

Home #:(_____)_____ **Cell** #:(_____)_____ Work #:(_____)_____

Please circle which option you'd prefer for appointment reminders/normal test results:

CALL TEXT EMAIL

Email Address: _____

Race: ☐ African American ☐ Indian/Alaska Native ☐ Asian ☐ Hispanic/Latino ☐ Native Hawaiian
☐ White ☐ Other: _____

Marital Status: ☐ Divorced ☐ Separated ☐ Single ☐ Widowed
☐ Married (list maiden name): _____

Spouse's Name: _____ Date of Birth: _____

Phone #:(_____)_____ Circle: Cell# Home# Work#

***Do we have your permission to share information with this person if they were to call?** YES / NO

Emergency Contact: ☐ Spouse (see above) ☐ Other (see below)

Name: _____ Phone #: (_____)_____

Relationship: _____

***Do we have your permission to share information with this person if they were to call?** YES / NO

Primary Care Physician Name: _____ Phone #: (_____)_____

Preferred Pharmacy: _____ Location: _____ Phone #: (_____)_____

Who can we thank for referring you to our office? ☐ Doctor _____ ☐ Internet
☐ Friend/Relative _____ ☐ Other _____
Primary Insurance: _____ Policy Holder's DOB: _____

Policy Holder's Legal Name: _____ SSN: _____

Relationship to you: ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

Secondary Insurance: _____ Policy Holder's DOB: _____

Policy Holder's Legal Name: _____ SSN: _____

Relationship to you: ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

****MUST HAVE BACK OF FORM COMPLETED AND SIGNED****

Release of Information

I understand that as defined by the privacy regulations pronounced pursuant to the Health Insurance Portability Accountability Act of 1996 (HIPAA), the information obtained or created will be safeguarded. We may use and disclose your individually identifiable health information for purposes of treatment, payment and health care operations. However, your personal health information (PHI) and accounting details will not be released to anyone without your consent, except as allowed by law. Our detailed Privacy Policy is available upon request, or you may request a copy mailed to you by contacting our office at any time. By signing below I acknowledge that I was offered a printed detailed copy of HIPAA Notice of Privacy Practices.

Assignment of Insurance Benefits & Payment Policy

I hereby authorize payment directly to Contemporary Obstetrics & Gynecology, P.C. for the surgical and/or medical services as described. I understand that I am responsible for payment of my bills and that my insurance company will be billed for any payable benefits as a service to me. **All Specimens are sent to LAB CORP unless otherwise requested. Any bills related to out of NETWORK labs will be the patient's responsibility**.

I hereby give my consent to Contemporary Obstetrics & Gynecology, P.C. for the testing to conduct analytical tests deemed necessary, on an ongoing basis to determine the absence or presence of: Alcohol, Class A Drugs (heroin, cocaine, etc.) and Class B Drugs (cannabis, amphetamines, etc.)
I authorize the release of information regarding my condition, as necessary, to process these and/or related claims.

Copays are due at the time of service: we accept cash, VISA, MasterCard, Discover, and personal checks. A $10.00 billing fee is assessed every month in which a balance is carried over 60 days. Please contact the billing department at (248)656-2022 with questions. There is a $35.00 fee for returned checks (NSF). When turned over to an outside agency for collection, collection costs of 35% will be applied to your current balance on your account.

I acknowledge I am at least 18 years of age, have read, understood and agree to abide by the policies described above. Further, all information I have provided is accurate to the best of my knowledge. If I wish to revoke this authorization, it must be done in writing.

As a courtesy to the other patient's schedule, if you are 15 minutes late for your scheduled appointment, YOU WILL BE REQUIRED TO RESCHEDULE FOR ANOTHER DAY. Your understanding in helping us maintain a timely office is greatly appreciated.

Signature: _____ Date: _____

Print Name: _____

Relationship to patient (if not patient): _____