DUNWOODY OBSTETRICS & GYNECOLOGY, P.C.
PATIENT REGISTRATION FORM

PERSONAL

FULL NAME _____ PREFER TO BE CALLED:_____

DATE OF BIRTH_____ AGE_____ SS#_____ MARITAL STATUS S M W D

HOME PHONE_____ CELL PHONE_____ E-MAIL _____

STREET(**NO PO BOX**)_____APT#_____ CITY_____STATE_____ZIP_____

PREFERRED PHARMACY AND **PHONE** #_____

EMPLOYER _____ADDRESS_____

OCCUPATION_____ WORK PHONE_____

I HEREBY AUTHORIZE INFORMATION TO BE GIVEN TO:_____ or **NO ONE** Please Circle

CONTACTS

NAME OF SPOUSE OR PARENT_____ RELATION_____

STREET_____APT#_____ CITY_____STATE_____ZIP _____

HOME PHONE_____ CELL PHONE_____WORK PHONE_____

EMPLOYER/ADDRESS_____OCCUPATION_____

NAME OF NEAREST RELATIVE OR FRIEND NOT LIVING WITH PATIENT_____

RELATION TO PATIENT_____HOME PHONE_____CELL PHONE_____

INSURANCE

PRIMARY INSURANCE CARRIER_____**ID #:**_____**GROUP#:**_____

NAME OF SUBSCRIBER_____DOB_____SSN:_____ RELATION TO PATIENT_____

SECONDARY INSURANCE CARRIER_____**ID #:**_____**GROUP#:**_____

NAME OF SUBSCRIBER_____DOB_____SSN:_____ RELATION TO PATIENT_____

1) **FINANCIAL POLICY:** We make every effort to keep the costs of your medical care to a minimum. Our fees are comparable to those of other specialists in our area with equivalent training, experience and credentials.
   a. **Insurance Filing**: We Participate in a number of insurance plans and will work with you and your insurance carrier. However, you must make sure that you understand and have met your plan obligations. Those obligations may include, but are not limited to: providing us with a **current** insurance card on every visit, paying the patient portion due at the time of your visit, and participating in the precertification process as determined by your insurance carrier where necessary. However, prior to surgery and/or delivery, we will assist you in determining your portion of the bill. **No insurance covers 100%**. There are always limitations, non-covered services and exclusions. For any concerns regarding your insurance coverage, please contact your carrier.
   b. **Patient Portion**: Regardless of insurance, payment remains your personal responsibility. Patient portions include deductibles, co-pays, co-insurance, and non-covered service charges. We collect all patient portions when services are rendered. We do not wish to cause an embarrassment for anyone, please let us know immediately if you have a financial issue or concern about our services. We accept cash, check and all major credit cards (AMEX . $100) for your convenience.
   c. **Appointment Cancellation Policy**: There is a 24 hour cancellation policy. If you fail to cancel your appointment within that time frame your account will be assessed a $25 fee, a $100 fee for failure to cancel a surgery performed in-office or at the hospital will be assessed.

2) **RECEIPT OF HIPPA PRIVACY PRACTICES:** I acknowledge that I have been given the Practice's Notice of Privacy Practices. I understand that if I have any questions or complaints I may contact the Practice's Privacy Official.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY AND ACKNOWLEDGE MY RECEIPT OF THE PRIVACY POLICY.
PATIENT SIGNATURE:_____**DATE:**_____

3) **MEDICAL RECORD AUTHORIZATION:** In order for us to care for you it is imperative that we have access to your records. Other entities may also require information contained in your medical record to care for you or pay for your services. AUTHORIZATION: I hereby authorize Dunwoody Obstetrics & Gynecology, PC to furnish information to insurance carriers and health care professionals as needed to coordinate my medical care.

I HAVE READ AND UNDERSTAND THE ABOVE MEDICAL RECORD AUTHORIZATION POLICY.
PATIENT SIGNATURE:_____**DATE:**_____

4) ASSIGNMENT OF INSURANCE BENEFITS: "Assignment" means that the patient agrees that the insurance carrier's payment for services rendered be made directly to the physician. This is not payment in full. ASSIGNMENT: I hereby authorize direct payment of any benefits payable for these medical services to Dunwoody Obstetrics & Gynecology, PC. I understand that I am financially responsible for payment of all services rendered regardless of insurance coverage.**PA**

I HAVE READ AND UNDERSTAND THE ABOVE ASSIGNMENT OF INSURANCE BENEFITS.
PATIENT SIGNATURE:_____**DATE:**_____

REFERRED BY:_____