Northlake OB/GYN
Patient Information Sheet

Last Name_____ First Name & Initial_____

Address _____

City_____ State_____ Zip_____

Date of Birth_____ Social Security #_____

Home Phone_____ Cell Phone_____ Primary # _____

Marital Status (M / S / D / W) Patient Race_____ Religion _____

Patient E-Mail Address_____

Patient's Employer_____Occupation_____

Employer's Address_____

City_____ State_____ Zip_____

Work Phone_____ Ext._____

Primary Pharmacy Info:

Name: _____addr: _____ ph # _____

How did you find us? (circle one) Internet Magazine Friend Physician - Dr. _____

Insurance Information

Primary Insurance Company_____

Member ID_____ Group #_____

Claims Mailing Address_____

_____

Insurance Phone Number_____

Policy Holder Last Name_____ Policy Holder First Name_____

Policy Holder Date of Birth_____ Policy Holder SS#_____

Relationship to Patient_____

Policy Holder Employer_____

Employer Phone #_____

Signature
I certify that the above information is true and correct to the best of my knowledge.

Patient or Legal Guardian Birthdate: _____

_____ Date _____

Section I: Financial Agreement & Assignment of Benefits

In consideration for the services to be rendered to me, I hereby assume full responsibility to pay for those services in accordance with the rates now in effect at Northlake Obstetrics & Gynecology, P.A., to the extent that I am legally responsible for such payment. Payments that I am responsible for may include, but are not limited to, balance after insurance, non-covered services, and deductibles.
I hereby assign to Northlake Obstetrics & Gynecology, P.A., any and all benefits for services rendered under insurance policies, reimbursement, or pre-paid healthcare plans. I acknowledge any balance not covered or paid for by such policies is my legal responsibility. I understand that if my account is turned over to a collection agency, a 30% service charge will be added to the balance. I understand that I am required to inform Northlake Obstetrics & Gynecology, P. A., of any address, phone number, or insurance changes.
THIS IS A LEGAL FINANCIAL AGREEMENT OF BENEFITS FORM. BE SURE ANY QUESTIONS YOU MAY HAVE ARE ANSWERED BEFORE YOU SIGN AT THE BOTTOM OF THE PAGE.

Section II: Receipt Acknowledgement for the Notice of Privacy Practices

I,_____ have been made aware of the Notice of Privacy Practices for Northlake Obstetrics & Gynecology, P.A., I understand that this notice states how Northlake Obstetrics & Gynecology, P.A., may use and disclose my Protected Health Information ("PHI").
I UNDERSTAND THAT A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST.

Section III: Medical Records Release and Forms

I understand that if I request a copy of my medical records to be sent to another doctor, I must allow 15 business days for processing from the time I submit a signed authorization. I understand that if I request my medical records to be released to me, I must pre-pay $25 for in-house records or $30 for records in storage and allow 15 business days for processing from the time I submit a signed authorization.
I understand if I submit a disability form, Family Medical Leave Act form, or any other form that requires a doctor signature and/or specific information to be completed, I will be charged $15 and must allow 10 business days for processing.
I,_____hereby authorize Northlake Obstetrics & Gynecology, P.A., to release any information, in the course of my treatment, necessary to process insurance claims and/or to any other requesting physician in reference to referrals or coordination of care.

Section IV: Release of Records to a Designated Third-Party

In addition to my treating physicians and medical facilities, I authorize Northlake Obstetrics & Gynecology, P.A., to release and discuss my medical/billing information and records to the following individuals. (This should include **friends or family members responsible for picking up your records when you are unable to do so.) PLEASE PRINT**

1. _____ Relationship: _____

1. _____ Relationship: _____

Patient Signature

By signing below I am verifying that I have read each of the four sections on this page.
I understand each section and consent to and agree with the information stated in each section.

_____ _____ _____
(Patient / Legal Representative Signature) **(Legal Representative's Relationship To Patient)** **(Date)**