

OB-GYN ASSOC. OF OAK RIDGE, P.C.

PATIENT INFORMATION SHEET

PAYMENT IS DUE WHEN SERVICES ARE RENDERED (*INCLUDES CO-PAYMENTS & CO-INSURANCE)

PATIENT'S NAME - LAST		FIRST	MIDDLE	MAIDEN NAME	MARITAL STATUS				
					S	M	W	D	SEP
AGE	BIRTHDATE		SOCIAL SECURITY #		RACE	HOME PHONE			
STREET ADDRESS				CITY	STATE	ZIP CODE	CELL PHONE		
POST OFFICE BOX	CITY	STATE	ZIP CODE	EMAIL ADDRESS					
PATIENT'S EMPLOYER				OCCUPATION (INDICATE IF STUDENT)		HOW LONG EMPLOYED ?	BUSINESS PHONE #		
EMPLOYER'S STREET ADDRESS				CITY	STATE	ZIP CODE			
SPOUSE OR PARENT'S NAME				BIRTHDATE	SOCIAL SECURITY #		PHONE #		
SPOUSE OR PARENT'S ADDRESS				CITY	STATE	ZIP CODE			
SPOUSE OR PARENT'S EMPLOYER				OCCUPATION (INDICATE IF STUDENT)		HOW LONG EMPLOYED ?	EMPLOYEEER PHONE#		
EMPLOYER'S STREET ADDRESS				CITY	STATE	ZIP CODE			
EMERGENCY CONTACT (NOT RELATED)			PHONE #	NAME OF NEAREST RELATIVE			PHONE #		

DRUG ALLERGIES

PHARMACY NAME		LOCATION	PHONE #
REFERRING PHYSICIAN		FAMILY PHYSICIAN	PHONE #
REFERRING PHYSICIAN ADDRESS		PHONE #	FAMILY PHYSICIAN ADDRESS

FINANCIAL INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE NAME		INSURANCE NAME	
FILING NUMBER		FILING NUMBER	
GROUP NUMBER		GROUP NUMBER	
SUBSCRIBER'S NAME		SUBSCRIBER'S NAME	
SUBSCRIBER'S BIRTHDATE	EFFECTIVE DATE	SUBSCRIBER'S BIRTHDATE	EFFECTIVE DATE
PATIENT'S RELATIONSHIP TO THE SUBSCRIBER		PATIENT'S RELATIONSHIP TO THE SUBSCRIBER	

All Professional Services rendered are charged to the patient. Necessary forms will be completed to help expedite Insurance carrier payments. However, the Patient is responsible for all fees, regardless of insurance coverage. Payment is due for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE OB-GYN ASSOCIATES OF OAK RIDGE, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Date _____ Signature _____

OB-GYN ASSOCIATES OF OAK RIDGE

WELCOME TO OUR OFFICE

Thank you for choosing OB-GYN Associates for your health care needs. Our goal is to provide the very best care and to assure that you are treated professionally and in a timely manner.

CANCELLATION POLICY

If you must cancel or reschedule your appointment we would appreciate at least a 24 hour notice. There will be a fee if proper notice is not given or for no show visits.

APPOINTMENT TIMES

Please arrive for your appointment at least 15 minutes early so the paper work can be completed and you can be called back on time. Please use our web site at www.obgynoakridge.com you can print off and complete the forms to bring with you. There is also a link to digiChart on our web site. This can be accessed with a username and password that is given to you when you make your appointment. This allows you to enter digiChart and complete your medical history. Electronic medical records are going to be mandatory in the near future and we would like to transition as easily as possible for your convenience. This will save you time in the future.

TELEPHONE MESSAGE PERMISSION

I, _____ give permission to the physicians and staff of OB-GYN Associates of Oak Ridge to leave messages regarding my care in the following manner.

____ May leave appointment reminders and lab results on my answering machine.

____ May leave appointment reminders and lab results _____

____ May only leave information with me. By electing this option it may delay you in receiving your critical results.

I prefer to be contacted at ____ Home ____ Work ____ Cell

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

>Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

>Obtain payment from third-party payers

>Conduct normal healthcare operations such as quality assessments and physician certifications.

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patients name or Legal Guardian: _____

Signature: _____ *Date:* _____