



## REGISTRATION FORM

### PATIENT INFORMATION

Patient's Legal Name \_\_\_\_\_ Date \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Marital Status     Married     Single     Divorced     Separated     Widowed  
 Social Security # \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse/Parent \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Referred By \_\_\_\_\_  
 Do you have any allergies to medication? (if yes, please explain)     No     Yes \_\_\_\_\_  
 In case of emergency, please contact (other than spouse/parent):  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### POLICY HOLDER INFORMATION

Policy Holder's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Policy Holder's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance _____	Secondary Insurance _____
Group # _____	Group # _____
Identification # _____	Identification # _____
Subscriber Name _____	Subscriber Name _____
Effective Date _____	Effective Date _____

### PAYMENT AND TREATMENT AUTHORIZATION

I, \_\_\_\_\_ HEREBY AUTHORIZE East Metro OB/GYN Specialists, Inc. to furnish information to insurance carriers concerning my present illness and treatments as long as I am under their care. I direct the insurer to pay, without equivocation, directly to East Metro OB/GYN Specialists, Inc. all benefits due them as a result of this claim. A photostat copy of this authorization will be as valid as the original. I understand that I am responsible for all charges including any collection agency fees, court costs, lab fees and any interest applied to outstanding balances. I also understand that payment is due at the time of services unless previous arrangements are made with management or the billing department.

I, \_\_\_\_\_ HEREBY AUTHORIZE the continuing medical treatment of \_\_\_\_\_

Signature of Patient (guarantor, if minor) \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE READ AND SIGN OUR FINANCIAL POLICY ON THE REVERSE SIDE OF THIS FORM.**

Upon completion of this form, please allow the receptionist to make a copy of your insurance card.

## FINANCIAL POLICY

Welcome to our practice. We appreciate the confidence you have placed in us. We are committed to providing you the best care available.

Please read and sign the following financial statement before any treatment.

- All patients (or guarantor if patient is a minor) must complete the registration form and sign the financial policy before treatment.
- Payment in full is expected at the time of service.
- We accept cash, checks, Visa or MasterCard.
- Prior approval must be made with management or the billing department if payment cannot be made in full.
- We are happy to submit a claim for payment to your insurance company provided we are informed of all insurance coverage and/or changes in insurance.
- Please note that any balances remaining after 60 days will transfer to PATIENT RESPONSIBILITY.
- We encourage you to become familiar with your benefits. When you are informed, it assists the billing department in filing your claim correctly.
- Any uncovered services, deductibles or co-pays will be paid at the time of service.
- East Metro OB/GYN Specialists, Inc. chooses not to charge our patients for missed appointments, although, we do appreciate a 24 hour notice for cancellation and to reschedule your appointment.

I have read and agree to this financial policy.

Signature of Patient (guarantor, if minor) \_\_\_\_\_ Date \_\_\_\_\_