GIFTS FROM GRACE OBGYN, LLC.

PATIENT REGISTRATION FORM

Date: **Patient Information** **Account #:**

Patient Name:	SS#:	Date of Birth:
Marital Status: S M Sep D W	Home Phone:	Cell Phone:
Street Address: (No PO Box):	City/State/Zip	
Mailing Address/P. O. Box:	City/State/Zip	
Occupation (Indicate if Student):	Employer:	
Employer Address:	Employer Number:	Length of Employment
Spouse/Significant Other/Parent or Guardian:	Date of Birth:	SS#:
Occupation:	Employer Address:	Employer Number:
Name and Age of children:		
Emergency Contact Name and Number:	Relationship	Referred by:
Do you have a PCP?	PCP Name:	PCP Phone #:
Insurance Carrier	Insured Name	DOB and SS#

Financial Policy Statements/Authorizations

A) **<u>Financial Policy:</u>** We make every effort to keep down the costs of medical care. Our fees are comparable to those of other specialists in our area with equivalent training, experience and credentials.

1) **Insurance Filing**: We participate in a number of insurance plans and will work with you and your carrier. However, you must make sure that your plan obligations are met. These obligations include: providing us with a <u>current</u> insurance card on every visit, paying the patient portion due at the time of your visit, using network providers for referrals (if necessary), and participating in precertification processes. Your insurance plan requires us to work together. **No Insurance covers 100%.** There are always limitations, non-covered services and exclusions. Even with 2 or more carriers, there may be services for which you are responsible. If you have questions regarding your coverage, they should be directed to your insurance carrier.

2) **Patient Portion Due**: Regardless of insurance, payment remains your personal responsibility. Your designated patient portion due may include: deductibles, co-pays, co-insurance, and non-covered service charges. **Our policy is to collect all patient portions due at the time of service.** If is our practice policy that if the patient's outstanding balance exceed $150, they may be asked to speak to someone in our Insurance Department <u>prior</u> to services being rendered. We do not wish to cause embarrassment for any patient. Please let us know immediately if you have a financial issue or question about our services. **For your convenience we accept cash, check and all major credit cards.**

3) **Collection Procedures:** If your account has gone into collections proceedings, resulting in Gifts From Grace to obtain outside assistance in collections of moneys due on this account. Your bill will be adjusted to include any fees or charges incurred by Gifts From Grace by that entity(ies). Most collection Agencies charges will be approximately 35% of the total balance submitted. This fee is subject to change without notice to the patient.

I have read and understand the above financial policy.

Patient Signature: ____ Date: __________________

B) **<u>Medical Record Authorization:</u>** It is imperative that to care for you we have access to your records. Other entities may also require information contained in your medical record to care for you or pay for services.

AUTHORIZATION: I hereby authorize GIFTS FROM GRACE to furnish information to insurance carriers, and health care professionals as needed to coordinate my medical care.

Patient Signature: ____ Date: __________________

C) **<u>Assignment of Insurance Benefits:</u>** "Assignment" simply means that the patient agrees that the insurance company's payment for services rendered be made directly to the provider. This is not payment in full.

ASSIGNMENT: I hereby irrevocably assign to GIFTS FROM GRACE all payments for medical services rendered to me by GIFTS FROM GRACE.

Patient Signature: ____ Date: __________________