

Patient Information

Name: _____

Last

First

MI

Patients Address: _____

Street Address

City

State

ZIP

Home Phone: _____ Work: _____ Cell: _____

Marital Status: _____ Date of Birth: _____ Email: _____

Employer _____

How would you like to be contacted for your test results/appointments? (circle one) Home Work Cell

It is ok for us to leave messages at this number? _____ Yes _____ No, please only speak directly with me.

Insured/Spouse/Parent/Guardian Information

Name: _____ Date of Birth: _____

Emergency Contact: _____ **Phone #:** _____ **Relation:** _____

Medical Procedure Policy

I hereby authorize the certified providers of Obstetrics & Gynecology of Atlanta to provide obstetrical and gynecology care for me. I give the providers permission to perform any necessary procedures after reviewing the procedure and the associated risks.

A Division of Atlanta Women's Health Group P.C.

Financial Policy

We are committed to meeting your health care needs. Our goal is to keep your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank may result in a \$25.00 returned check fee being charged to your account.
2. It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit.
3. It is your responsibility to contact your insurance carrier to confirm that our physicians participate on your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.
4. If your plan requires a referral it is your responsibility to obtain this prior to being seen by the doctor. If we are required to obtain that referral for you, please notify our office 72 hours prior to the specialist visit so that we can have ample time to acquire this information from your insurance company.
5. All co-payments are due at the time of service. A \$25.00 service fee will be charged for failure to pay the co-pay amount at the time of service.
6. If you miss your appointment, you may be charged a No-Show fee of \$25.00 for each appointment missed.
7. Laboratory services may be provided by Quest Diagnostics, Lab Corp., Genzyme, and NTD Laboratory. All of these are contracted labs. Labs billed by our office will be billed by Phyttest, an independent lab billing service.
8. All medical records request must be in writing and received in our office 72 hours prior to the date needed. Records over 10 pages will only be mailed not faxed and all medical records request will have a fee based on the number of pages. The range of fees for this service is from \$10.00 - \$50.00. Occasionally, the fee could be over \$50.00 if there are excessive pages to copy.

I understand that I am responsible for any amount that my insurance does not cover.

I have reviewed a copy of Obstetrics & Gynecology of Atlanta Notice of Privacy Practices

******For your convenience, we accept Cash, Checks, Visa, MasterCard, American Express and Discover******

Your signature below signifies your understanding and willingness to comply with this policy.

Patient signature: _____ **Date:** ____/____/____