PATIENT INFORMATION FORM

How did you hear about us? _____

RACE: * Black/African American * American-Indian * White * Native Hawaiian/Islander * Other * Refuse to Answer

MARITAL STATUS: * Single * Married * Separated * Divorced * Widowed

GENDER: * Male * Female

Do you have a primary physician? _____

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Driver's License No. _____ State: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Email Address: _____

Primary phone number for contact: _____ Cell/Work/Home

Additional number for contact: _____ Cell/Work/Home

Is your mailing address the same as your physical address? Yes/No
If different, please list below:

Address: _____ City: _____ State: _____ Zip: _____

Are you currently employed? Yes/No

Name of Employer: _____ Work Phone: _____

Employer's Address: _____

EMERGENCY CONTACT

In case of emergency, notify: _____ Relationship: _____

Emergency contact Address/City/State/Zip/Phone Number: _____

_____

FINANCIAL RESPONSIBILITY

Who is the financial responsible party for your visits? Self * Spouse * Parent * Guardian * Other

If the responsible party is not you, the patient, please provide the following about the responsible party:

Last Name: _____ First Name: _____ Middle/Maiden: _____

Social Security Number: _____ Date of Birth: _____

Cell Phone Number: _____ Work Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Employer and Address: _____

_____

Insurance Authorization and Assignment: I hereby authorize my insurance company and any other responsible third party, to pay directly to Gulfport OB-GYN Clinic and benefits due me for services rendered by Gulfport OB-GYN Clinic. I understand that I am financially responsible for any charges not covered by this assignment. I also understand that I am responsible for any unpaid balance due to Gulfport OB-GYN Clinic.

Signature of Insured Responsible Party: _____ Date: _____

HEALTH INSURANCE INFORMATION

Primary Insurance Company: _____ Policy Number: _____

Group Number: _____ Name of Policy Holder: _____

Date of Birth for Insured: _____ Employer: _____

ID or Social Security Number (if other than patient): _____

Relationship to Policy Holder? Self * Spouse * Child * Guardian * Other: _____

Insurance Authorization and Assignment: I hereby authorize my insurance company and any other responsible third party, to pay directly to Gulfport OB-GYN Clinic and benefits due me for services rendered by Gulfport OB-GYN Clinic. I understand that I am financially responsible for any charges not covered by this assignment. I also understand that I am responsible for any unpaid balance due to Gulfport OB-GYN Clinic.

Signature of Patient: _____ **Date:** _____

DO YOU HAVE A SECOND INSURANCE PLAN? YES NO

Insurance Company: _____ Policy Number: _____

Group Number: _____ Name of Policy Holder: _____

Date of Birth for Insured: _____ Employer: _____

ID or Social Security Number (if other than patient): _____

EXAMINATION CHAPERONE POLICY NOTIFICATION

In order to help assure the highest quality of health care and professionalism, Gulfport OB-Gyn Clinic requires that a nurse be present during the physical examination part of your office visit.

By signing below, you are certifying that you have received and understand this policy notification. Your understanding and cooperation in this matter are greatly appreciated.

_____ _____

Patient or Guardian Signature Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I have been presented with a copy of the notice of privacy practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____ _____

Patient or Guardian Signature Date

Relationship if not signed by patient: _____

Witness: _____

NOTIFICATION OF LAB RESULTS

If my lab results are all normal, I would like Gulfport OBGYN to leave a voice mail at the following number: _____ Patient Initials: ___

If my lab results are all normal, **I DO NOT WANT** Gulfport OBGYN to leave a voicemail. I want to speak to a nurse. Patient Initials: _____

FMLA/DISABILITY PAPERWORK

Additional paperwork required by an employer or disability company is not a routine part of care from Gulfport OBGYN. However, Gulfport OBGYN is happy to fill out a variety of forms subject to the following fees:

FMLA (Family Medical Leave Act) - $10.00
Disability (Aflac, Colonial life, etc): $20.00

Gulfport OBGYN will fax/mail all paperwork to the employer, the disability company, or patient after fees are paid. If medical records are required, these are provided in the fees associated above.

All other documents requiring detailed medical information are subject to nominal fees:

1 page - $5.00
2 pages - $10.00
3 or more pages - $ 20.00

The above fees apply to paperwork needed for the patient's spouse, family member, guardian, or any other individual that will provide care/assistance for the patient.

Please allow 7-10 business days for patient paperwork to be completed.

Patient Signature: _____ Date: _____

GULFPORT OBGYN CONTROLLED SUBSTANCE PRESCRIPTION AGREEMENT

Depending on your specific care needs, your provider may prescribe you something that is deemed a controlled substance. To adequately care for you, the patient, please review the following agreement and sign. Failure to do so will prohibit you from receiving the medication you may need.

- This Agreement is essential to the trust and confidence necessary in a provider/patient relationship.
- If I break this Agreement, my provider will stop prescribing me controlled substances.
- I will communicate fully with my provider regarding all medications I am taking, over the counter or prescribed. I understand that certain medications may have an adverse effect; therefore my provider must be made aware.
- I will not share my medication with anyone.
- While being treated by Gulfport OBGYN, I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider. If necessary to do so, I will communicate immediately with my provider.
- I will safeguard my medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.
- I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
- **I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber by checking the Mississippi Prescription Monitoring Program web site periodically throughout my treatment period.**
- This agreement will remain in my administrative file and will be updated annually.

I agree to follow these guidelines that have been presented to me. _____ (Initial here)

This Agreement is entered into on this _____ day of _____, 201__.

Patient Signature: _____

Patient Name (printed): _____

Witnessed by: _____

Gulfport OB-GYN Clinic, P.A.

Patient's Financial Responsibility Statement

We are very pleased to inform you that as a courtesy to our patients we file all claims with your insurance company(s) for all health care services provided during your visit.

- Before each visit, we encourage you to contact your insurance company to discuss what is covered, what is not covered, and what your financial responsibility is for office visits, laboratory procedures, ultrasounds, bone density scans, and mammograms. This will ensure you have an estimate of what your out of pocket costs will be for each visit and/or service provided.

- We will file secondary insurance as a courtesy for you. However, we **do not** accept any write-downs or adjustments on secondary policies.

- At the time of your appointment, we will collect your deductible (or any balance on your account) and any copayment or coinsurance due for services provided based on your verified benefits. We accept cash, checks, and credit cards. New OB patients will be asked to meet with one of our Patient Account Representatives to explain payment options available.

- We accept CareCredit as a payment alternative. www.carecredit.com

- Your physician may provide a service based on his/her professional judgment that is later deemed a "non-covered benefit," by your insurance. If you receive a "non-covered benefit" notice from your insurance company, please call them for more information before you contact our office.

- Should you have a balance due; three statements will be mailed in the attempt to collect final payment. Any account not paid by you will be placed with our collection agency. **You will be responsible for all collection fees and any associated attorney's fees.**

- Checks returned to the clinic for insufficient funds will be turned over to the District Attorney's office.

- Gulfport OB-GYN will try to promptly refund any overpayment made by the patients. Please call our office if you feel an overpayment has been made so that we may review your account.

- Patient account questions: 228-678-9134

- Please sign below to authorize your insurance company to pay us directly and to acknowledge your understanding of your financial responsibility to Gulfport OB-GYN Clinic, P.A.

"I hereby authorize my insurance benefits to pay Gulfport OB-GYN Clinic, P.A. directly for any benefits due me for all health service provided. I understand that I am financially responsible for any charges not covered by my insurance company. I also hereby authorize the release of any medical information to my insurance company(s), or other responsible third parties."

_____ Calendar Year:

PATIENT (SIGNATURE)

_____ _____

PLEASE PRINT NAME DATE

_____ _____

WITNESS DATE