OB/GYN SPECIALISTS LLP
ANNUAL UPDATE PATIENT INFORMATION FORM

Patient Name:____
Last First M

Date of Birth:______________________ Social Security #______________________

Race:__________________________ Marital Status:________________________

Address for Billing:____

City:__________________________________ State:_______________ Zip:______________

Patient Home Phone: (_____)_______-________ Patient Work Phone: (_____)_______-________

Patient Cell Phone: (_____)_______-________

Patient Employer: ____

Spouse's Name: _________________________________ Social Security# _________________________

Spouse's Employer: ____________________________ Spouse DOB_____________________________

Spouse's Work Phone: (_____)_______-________ Cell: (_____)_______-________

IN CASE OF AN EMERGENCY, NOTIFY: ____

Relationship to patient: __________________________ Home# (_____)_______-________

Cell# (_____)_______-________

Responsible Party: ____

Address (if different from above): ____

Primary Insurance Company: (Current ID Card must be provided at Check In) ___________________________

Secondary Insurance Company: (Current ID Card must be provided at Check In) _________________________

Contracted Lab:__________________________________ Contracted Hospital: __________________

I understand the importance of current billing information and know it is my responsibility to keep this office informed of any changes in my insurance company or personal billing address. I realize any claims that are denied or delayed for timely filling due to this information not being updated are my responsibility. By signing below, I verity the information above is correct and current as of the date indicated.

Demographic and Insurance Information above is correct as verified by:

Name Date

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AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT OF BENEFITS

Patient Name: ____

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign and authorize payment to OB/GYN SPECIALISTS LLP of all medical/surgical and major medical benefits to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept responsibility, including, but not limited to payment of those fees and charges not directly reimbursed to OB/GYN SPECIALISTS LLP by any insurance policy, self-insurance plan or other benefit plan.

I understand that if I am insured by Medicaid that I accept responsibility for following the guidelines set forth by Medicaid. I understand that if Medicaid deems that I obtain referrals that it is MY responsibility to insure that this is given to my Obstetrician/Gynecologist by **MY ASSIGNED PRIMARY CARE PHYSICIAN.**

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of the authorization.

____

Person Providing Authorization   Date

____

Relationship to Patient