OCOEE OB/GYN, PC

PATIENT INFORMATION: ***PLEASE GIVE COMPLETE LEGAL NAME. IF YOU ARE USING SOMEONE ELSE'S INFORMATION TO COMPLETE THIS FORM YOU WILL BE PROSECUTED TO THE FULLEST EXTENT OF THE LAW.***

Last Name ________________________________ First Name _____________________________ Middle Name______________

Maiden Name _____________________ Marital Status: S M D W (Circle One)

Address ____ Apartment #_____________

City_______________________________________ State_______ Zip__________

SS#_____-____-______ DOB: ___/___/____ Home # (____) ______-________ Cell # (____) ______-_________

Email ____ Only put your email if you want to receive medical information this way.

Employer _____________________________ Work # (____) ______-_________Ext _____ Shift 1st 2nd 3rd (Circle One)

Nearest relative ***NOT*** living with you ____________________ Relationship_________ Phone (____) ______-_________

Referred By ____

BELOW ARE QUESTIONS CONCERNING YOUR SPOUSE/PARENT/GUARDIAN (COMPLETE IF MARRIED OR MINOR)

Last Name __________________________First Name ____________________ MI________ Relationship____________

Address____ Apt # _______ City_______________ State_____ Zip_________

Home # (____) ______-________ Work # (____) ______-_________ Cell # (____) ______-_________

SS# _________________________ Employer ____

COMMUNICATION CONSENT

In compliance with federal law, it is the policy of Ocoee OB/GYN to **NOT** release confidential, personal, and/or unauthorized information by home telephone, answering machine, work telephone, pager and/or fax. We will not leave a message on an answering machine where the greeting/announcement does not identify the name or number called. Information will not be left with an unauthorized person who may answer your telephone. A copy of this privacy practice acknowledgement is available upon request.

Please list authorized numbers: (APPOINTMENTS)

Home Telephone (____) ______-_________ Is it ok leave a message on your answering machine? Yes / No

Work Telephone (____) ______-_________ Is it ok to leave a message/voicemail? Yes / No

Cellular Telephone (____) ______-_________ Is it ok to leave a voicemail? Yes / No

If you would like to have your medical information released to someone other than yourself, please complete the following: I authorize Ocoee OB/GYN to leave medical information pertaining to my care by the following methods and will assume responsibility to notify Ocoee OB/GYN if this information changes.

Please list authorized names & numbers: (HIPAA)

Spouse/Significant Other: __________________ Ph. # (____) ______-______ Parent:_________________ Ph.# (____) ______-_______

Brother/Sister: _________________ Ph.# (____) ______-_______ Son/Daughter: :_________________ Ph.# (____) ______-_______

Patient's signature: ___________________________ Printed Patient's Name: _____________________________

Date: ____/____/____ ***Office Use Only: Account #*** ______________

OCOEE OB/GYN

Center for Women's Health

2550 Business Park Drive NE, Cleveland, Tennessee 37311
423-339-8881 or 866-340-4454 & Fax 423-464-6126
Brenda A. Snowman, MD, FACOG Delmon E. Ashcraft, Jr., MD, FACOG Michelle G. Davis, PA-C
Linda L. Foster, CNM Jennifer A. Lipps, CNM Lee Ann Stabler, CNM

Insurance Information

PRIMARY INSURANCE CARRIER

Plan Name ___________________________________

Policy # _____________________________________

Group # _____________Effective Date ____________

Name of Policy Holder ________________________

Policy Holder's Place of Employment:

____

Relationship to Patient ___________DOB__________

SECONDARY INSURANCE CARRIER

Plan Name ________________________________

Policy # ___________________________________

Group # _____________Effective Date _________

Name of Policy Holder ________________________

Policy Holder's Place of Employment:

____

Relationship to Patient ___________DOB________

Financial Policy and Agreement

We hope to make your visits with us as pleasant as possible. We also want you to have a full understanding of your financial responsibility. Please review and sign our financial policy. Ocoee OB/GYN's relationship is with you. We will not compromise your medical care to satisfy **ANY** insurance company. Bear in mind, insurance is meant to help defray the cost of medical care, **NOT** dictate your treatment.

Payment is due and expected in full at the time of service unless other arrangements are made PRIOR to your appointment. This includes deductibles, co-payments, co-insurance and non-covered services. If we are a non-participating provider with your Managed Care Organization you agree to pay for charges associated with the services rendered.

Please be advised that Pathology, Lab and Radiology services are billed by separate facilities and not by this office. It is your responsibility, not ours, to know the facilities and providers which are covered under you plan.

As a courtesy we will assist you in the filing of claims, completing forms, and pre-certification. You will be responsible for any and all balances not covered by your insurance including investigative procedures. If your insurance has not paid their portion within 60 days of being properly billed, the entire balance will be your responsibility. The **ULTIMATE RESPONSIBILITY** for the correct filing and processing of claims, however, **REMAINS WITH YOU**. If you are unsure of any specific requirements of your insurance, **PLEASE ASK THEM**.

REQUEST TO PAY BENEFITS TO PHYSICIAN AND/OR REQUEST TO RELEASE INFORMATION: I hereby request payment be made directly to the attending physician for the medical services, if any, otherwise payable to me for services rendered. I hereby request the attending physician to release any information to my insurance company required in the course of my examination or treatment.

If you do not have insurance coverage, a self-pay discount will be given when payment is made. Payment is expected at the time of service. If after processing your claim the insurance company denies charges and doesn't require us to take a contractual adjustment, a self-pay discount will be applied to the balance remaining.

You will receive a monthly statement requiring payment on any unpaid balance. If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred up to 30%. If your account goes to court, there will be additional court costs added to your responsibility. If we find it necessary to turn your account over to a collection agency, we will no longer be able to see you as you will be dismissed from our practice.

CONSENT TO WIRELESS TELEPHONE CALLS/TEXTS: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text message, including but not restricted to communications regarding billing and payment for items and/or services and appointment reminders, unless I notify Ocoee OB/GYN to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from Ocoee OB/GYN, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

CONSENT TO EMAIL USAGE: If at any time I provide an email address at which I may be contacted, unless I notify Ocoee OB/GYN to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from Ocoee OB/GYN.

There is a fee (currently $25.00) for any checks returned by the bank.

We are here to serve your health needs and will work hard, on your behalf, to contain fees and other charges while delivering you with quality health care. As our expenses rise and our reimbursement falls however, we are forced to charge for services that cost us money that we used to provide free of charge. They include the following:

-In accordance with Tennessee State Code [Annotated, Section 63-2-102 (a) (2) (A) (iii)], there is a $20.00 minimum fee for obtaining a copy of your medical records. This fee must be paid at the time of pick up.

-There is a $5.00 fee for the completion of any forms brought into our office from an outside organization and/or facility such as FMLA forms unless they are not considered global to your care. The fee must be paid prior to us faxing the form or at the time of pick up.

-There is a $25.00 fee for generating any type of letter used to validate a medical diagnosis, appeal a denial for medication, etc.

-Should you miss more than three appointments with our office, a $25.00 “NO-SHOW” fee will be charged for every occurrence thereafter.

I have read and understand the above policies. I understand that I may receive a copy of this form upon request.

_________________________________ _______________________________

Print Patient’s Name **Signature of Patient or Responsible Party**

____________________________ Date _____/_____/_____

Relationship to patient if Minor

_________________________________ Date _____/_____/______

Witness (office use only)

____

Account # (office use only)

MEDICATION LIST

YOUR NAME: ______________________________ **DOB:**______________ **DATE:**_____________

NAME OF MEDICATION	DOSE	HOW OFTEN DO YOU TAKE THE MEDICINE	REASON FOR TAKING THE MEDICATION	DATE STARTED TAKING THE MEDICATION	WHO PRESCRIBED IT

MEDICATION ALLERGIES: ____
____
____

WHAT PHARMACY DO YOU USE? ____

WHAT IS YOUR PHARMACY'S ADDRESS? ____

WHAT IS YOUR PHARMACY'S PHONE NUMBER? ( ) - __ __ __ - __ __ __ __