PATIENT INTRODUCTION SHEET

Name:______________________________ Age:__________ DOB:______________

Social Security #______________________ Home Phone:______________________

Cell Phone:__________________________ Email Address:____________________

Mailing Address: ____________________City/State/Zip:______________________

Employer: ________________ Occupation: ______________ Work Phone: ________

Husband's Name:________________ DOB:__________ Social Security # ____________

Husband's Employer: ____________________ Phone:__________________________

Emergency Contact: ______________________ Relationship to you:______________

Cell Phone: ________________ Work Phone: ______________ Home Phone: __________

Your Insurance Company: ____________________ Group/Policy #__________________

Other Insurance (Husband's or secondary)____________________ Group/Policy #________________

Referring/Primary Physician:______________________ Pharmacy: ________________

Person Responsible for payment (if other than yourself): ____________________________

Relationship: ____________________ Phone: ____________________________

Social Security # ______________________ DOB: ____________________________

Place of employment: ____

Their address: ________________________ City/State/Zip:____________________

It is my responsibility as the patient to determine if my insurance covers evaluation and treatment by a nurse practitioner. (signature required) __________________

IN AN EFFORT TO MAINTAIN REASONABLE CHARGES,
WE REQUEST THAT YOU PAY FOR YOUR SERVICES AT THE TIME OF EACH VISIT.

I HEARBY AUTHORIZE HERITAGE OB/GYN TO FURNISH INFORMATION CONCERNING MY TREATMENT TO INSURANCE COMPANIES AS DEEMED NECESSARY AND I HEARBY IRREVOCABLE ASSIGN TO HERITAGE OB/GYN ALL INSURANCE BENEFITS PAYABLE TO ME BY INSURANCE AND THIS AUTHORIZATION. HERITAGE OB/GYN CANNOT ACCEPT RESPONSIBILITY FOR COLLECTING INSURANCE CLAIMS OR FOR NEGOTIATING AN INSURANCE SETTLEMENT ON A DISPUTED CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY ACCOUNT.

Signed:______________________________ Date:__________________________

I acknowledge that final responsibility for all charges in regards to my treatment rest with me. I accept responsibility for all charges to include all finance charges. In the event that HERITAGE OB/GYN is forced to utilize the services of attorneys, collection agencies, or other professional agencies to collect money on my account, I accept responsibility for all collection fees, attorney fees, finance charges and all other costs incurred in the collection process and hereby authorize those charges.

THE DOCTOR WILL TAKE A COMPLETE MEDICAL HISTORY FROM YOU; HOWEVER, PLEASE COMPLETE THE FOLLOWING INFORMATION AND FEEL FREE TO NOTE ANY OTHER INFORMATION YOU FEEL WOULD BE PERTINENT TO YOUR HEALTH.

Purpose of this Visit: __________ Pregnancy
__________ "Annual" examination
__________ Gynecological Problem
__________ Other: ______________________________

Drug Sensitivities / Allergies:

____

____

Medications presently taking:

____

____

____

Past Hospitalizations / Surgical procedures:

____

____

____

Other:

____

____

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We reserve 5-7 days processing time for medical records.
While we make every effort to accommodate the insurance needs of our patients, it is the patient's responsibility if pre-certification is required or if the provider you will be seeing is covered by your insurance company.

Signed: ___________________________________ Date: ___________________________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION BY TELEPHONE

I, ____________________________, do hereby authorize Heritage OB/GYN Clinic to release information concerning my medical condition and/or medical history during telephone conversations with the following person(s) (i.e. mother, father, husband, etc...)

____

____

____

I accept that Heritage OB/GYN Clinic does not have the ability to verify the identity of individuals who call requesting this information.

Signed: ____

Date: ____

Witness: ____

Date: ____

Our routine protocol requires that no medical information be given out over the phone without a written consent from the patient.

Financial Agreement

I fully understand that I am ultimately responsible for any and all charges associated with my account. If I fail to pay any amount due and the account is referred to a collection agency and/or attorney, I will also be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of any balance due.

Signed: ______________________________ Date: _________________________