

Acct#: \_\_\_\_\_

Please Print Clearly

Date \_\_\_\_\_

Patient's Legal Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Address: Street \_\_\_\_\_ Unit# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ MaritalStatus \_\_\_\_\_ SS# \_\_\_\_\_ Race \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Who referred you to our office \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Emergency Contact

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Work Phone \_\_\_\_\_

**CONSENT TO CONTACT**

If Rocky Mountain OB-GYN, P.C. needs to contact me regarding any future appointments or give test results they may leave a message. Yes or No Please specify phone number you prefer us to call: \_\_\_\_\_.

Signature \_\_\_\_\_

**GUARANTOR/SPOUSE/ PARENT INFORMATION**

Guarantor/Spouse Legal Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Address: Street \_\_\_\_\_ Unit# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Employer Name \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Patient's Relationship to Guarantor: Spouse \_\_\_\_\_ Child \_\_\_\_\_ Legal Guardian \_\_\_\_\_ Other \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Company and Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Insurance Group Name \_\_\_\_\_ Group# \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Policy# \_\_\_\_\_

Do you have secondary insurance: Yes No Is this a Medicare supplementary policy? \_\_\_\_\_

Secondary Insurance Company and Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Insured's Group Name \_\_\_\_\_ Group# \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Policy# \_\_\_\_\_

## CONSENT FOR TREATMENT

I, the undersigned, voluntarily agree to tests, procedures, and/or treatments, which the attending physician or healthcare professional and I have discussed and deemed necessary and which is administered to be performed on me under the direction of the physician or healthcare professional or his/her designee.

INITIAL: \_\_\_\_\_

## PAYMENT TERMS AND AGREEMENTS

I, the undersigned, in consideration for services rendered to the patient by Rocky Mountain OB-GYN, understand and agree to the following:

1. I understand that payment for charges is due on the date of service with the exception of insurance carriers for which Rocky Mountain OB-GYN is under contract to file directly.
2. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment from Rocky Mountain OB-GYN. I will be responsible for any co-payment, deductible or service not covered by my insurance provider. If I do not have insurance coverage for services rendered by Rocky Mountain OB-GYN, I agree to pay all charges resulting in such services.
3. I hereby authorize Rocky Mountain OB-GYN to file with my insurance carrier and I assign payment of medical benefits to Rocky Mountain OB-GYN.
4. I authorize release of any and all medical records and information necessary to process any claim generated by services I received in this office.
5. I will keep my account current as to charges for which I am responsible. In the event that I fail to pay charges, Rocky Mountain OB-GYN is entitled to take whatever action necessary to collect such charges and I will be responsible for reasonable attorney's fees and costs incurred as a result of such collection.

**NOTICE:** Your records will only be stored for ten years following your last visit in our office, then destroyed according to our office policy.

INITIAL: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

I, the undersigned, have read the Notice of Privacy Practices and fully understand my rights and how my medical information may be used and disclosed and how I can get access to this information.

INITIAL: \_\_\_\_\_

**My signature below indicates that I have read, understand and agree to all terms set above:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please bring this information sheet with you when you arrive for your appointment.*