ADVANCED OBSTETRICS & GYNECOLOGY

W. Eric Frohn, M.D. Robert Barnett, M.D. Leo Bautista, M.D.

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P.O. BOX 2430 ~ 726 COULTER DRIVE ~ NEW ALBANY, MISSISSIPPI 38652
PHONE (662) 534-4121 ~ FAX (662) 534-4172

NEW PATIENT REGISTRATION

NAME_____DATE OF BIRTH_____

PREFFERED NAME_____

ADDRESS_____APT#_____

CITY_____STATE_____ZIP_____

E-MAIL ADDRESS_____

HOME PHONE#_____CELL PHONE#_____

SOCIAL SECURITY #_____MARRIED____SINGLE____
DIVORCED__OTHER__

EMPLOYER_____WORK PHONE_____

SPOUSE'S NAME_____EMPLOYER_____

SPOUSE'S DATE OF BIRTH_____SPOUSE'S SS#_____

EMERGENCY CONTACT PERSON_____

RELATIONSHIP_____PHONE#_____

PHARMACY YOU WILL USE FOR MEDICATION TO BE CALLED INTO IF ANY IS PRESCRIBED

NAME_____TOWN_____

RESPONSIBLE PARTY (if other than patient)

NAME_____RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE #_____CELL PHONE#_____EMPLOYER_____

SOCIAL SECURITY #_____DATE OF BIRTH_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____INSURED'S NAME_____

SECONDARY INSURANCE_____INSURED'S NAME_____

CONSENT FOR TREATMENT

The undersigned hereby consents to the furnishing of any and all examinations, treatments, procedures, laboratory procedures, drug and supplies to the patient as ordered or requested by the patient's physician and acknowledges that no guarantee or assurance has been made as to the results of such treatments, procedures, or examinations.

SIGNATURE_____DATE_____

IMPORTANCE NOTICE REGUARDING ADDITIONAL CHARGES FOR LABS

There may be additional billing for labs that was not on your original visit. If you had a pap smear or other labs that has to have additional readings you **WILL BE BILLED AT A LATER DATE THAN YOUR ORIGINAL DATE OF SERVICE.** The undersigned consents to additional billing if necessary.

SIGNATURE_____DATE_____

NOTICE OF RECEIPT OF HIPPA PRIVACY PRACTICES FOR ADVANCED OBSTETRICS & GYNECOLOGY, PC

I hereby certify that I have reviewed a copy of the **HIPPA** Privacy Practices of Advanced Obstetrics & Gynecology, PC. If you would like a copy of this for your records, please see the receptionist.

PATIENT SIGNATURE_____DATE_____

WITNESS_____DATE_____

MEDICAL WAIVER

This is to authorize my medical provider & related medical personal at ADVANCED OB/GYN to speak with the people listed specifically below and to discuss with them the medical treatment I have been receiving from her/him and the above clinic and any other matters related to that medical treatment.

This authorization shall remain in effect until such time as it is withdrawn by me, in writing, regardless of the date signed.

CONTACT_____**RELATIONSHIP**_____

CONTACT_____**RELATIONSHIP**_____

CONTACT_____**RELATIONSHIP**_____

DATE THIS THE _____**DAY OF** _____**, 20**_____

SIGNED_____

WITNESS_____

COMMUNICATIONS REGUARDING MY ACCOUNTS WITH ADVANCED OBSTETRICS & GYNECOLOGY

UNTIL my accounts are paid in full, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as cell phone, landline, or text number that I provide, auto dialer systems, voicemail messages and other forms of communications.

PATIENT_____**DATE**_____

RESPONSIBLE PARTY_____**DATE**_____

WITNESS_____**DATE**_____

STATEMENT OF FINANCIAL RESPONSIBILITY: Unless otherwise prohibited, I unconditionally guarantee payment in full to Advanced OB/GYN, its physicians, and other healthcare professionals that may render treatment and services to me.

I hereby authorize and consent to the release of all medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) by or to the hospital and by or to any and all healthcare professionals involved in my care; Interpretation of test results; account billing and collections; payment posting and/or processing; or related healthcare functions. This authorization shall remain in effect until such time as all account balances extending from the encounter have been fully satisfied.

I authorize the hospital and all clinical providers who have provided care or interpreted my test, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using 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.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign and authorize and direct payment to Advanced OB/GYN or any other healthcare provider of all insurance benefits, including those provided under Medicare and Medicaid under Title XVIII/XIX of the Social Security Act, payable under their respective terms for my services and medical treatment. Unless otherwise provided by law, the filing or processing constructed as the assumption of any duty by Advanced OB/GYN with regard to the insurance.

To the extent allowed by law, I remain responsible for any portion of the hospital bill not paid by insurance, including co-insurance, denied claims or deductibles; I understand that if a private room is request or provided, I am responsible for any additional unpaid charges incurred.

RELEASE OF INFORMATION: In addition to that provided above, the hospital and its physicians may disclose all or any part of the patient's record when such disclosure is necessary for my continued treatment, the payment for the services I receive, for healthcare operation or as may be required or allowed by applicable law. For detailed information about how your healthcare information may be used, please review Advanced OB/GYN Notice of Privacy Practices. I permit a copy of these authorizations and assignment to be used in place of the original.

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Signature of Patient/Guarantor Date

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Signature of Patient Representative Date

Relationship to Patient_____