

Account #: \_\_\_\_\_

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



**Patient Information**

No Changes to Patient Information

Last Name, First Name Middle Name

Street Address P.O. Box/ Apartment # City

State Zip Code Date of Birth  
( ) ( ) ( )

Home Phone Mobile Phone Work Phone

Former Name Social Security # Marital Status

Occupation Employer Email Address

Referred By Primary Care Physician Primary Care Physician Phone #

**Insurance Information**

No Changes to Insurance Information

Primary Policy Holder's Name Date of Birth Social Security # Relationship to Patient

Secondary Policy Holder's Name Date of Birth Social Security # Relationship to Patient

**Emergency Contact**

( ) ( )  
Name Relationship to Patient Home Phone Mobile Phone





Privacy Health Information Consent

HIPAA Privacy allows you the right to restrict use and disclosure of your Personal Health Information. You are allowed the right to request confidential communication using alternative means such as correspondence. Please allow us at FSOBGYN to protect your rights to privacy by filling out and consenting to your personal restrictions in communications.

I, \_\_\_\_\_ (Patient Name) give permission to disclose my health information and account information to all listed parties below (spouse, children, and/ or other family members).

Four sets of horizontal lines for listing parties to whom health information is disclosed.

May we leave a message with detailed information? HOME: Y N WORK: Y N CELL: Y N
May we leave a message with call back number only? HOME: Y N WORK: Y N CELL: Y N
Other? \_\_\_\_\_

Written Communications/ Mailings? (Excludes Certified Letters) HOME: Y N WORK: Y N

Authorization and Release

I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION INCLUDING DIAGNOSIS, MEDICAL RECORDS, TREATMENT AND/OR CARE RENDERED TO ME OR MY CHILD DURING THE PERIOD OF CARE GIVEN BY FSOBGYN GROUP TO THIRD PARTY PAYORS AND/OR PRACTITIONERS . I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO FORT SANDERS OBGYN GROUP PC. I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF AND DEPENDENTS.

I AM AWARE THAT PATHOLOGY AND LABORATORY SERVICES FOR EVALUATION AND DIAGNOSIS ARE NOT BILLED THROUGH FSOBGYN AND MAY REQUIRE OTHER PARTIES TO BILL ME.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date