STAFF USE	
Account #:	
Date:	
DOB:	



Fill Out Each Year								
rst Name	Middle Name	Preferred Name						
Primary Contact Number / Type (cell, home, work)								
P. O. Box/Apartment #								
	State	Zip						
Social Security #		Marital Status						
	Former Nam	e (if changed in the last 5 years)						
Relation		Contact Phone Number						
		Contact Phone Number						
Street Addr	ess / City	*Pharmacy Phone Number						
Street Addr	ress / City	Pharmacy Phone Number						
Policy Holder Information (Please Fill Out Each Year)								
Date of Birth	Social Security #	Relationship to Patient						
Date of Birth	Social Security #	Relationship to Patient						
	P. O. Box/Apart Social Security # Relatio Relatio Street Addr Street Addr Fill Out Each Year) Date of Birth	I, home, work) P. O. Box/Apartment # State Social Security # Former Nam Relation Street Address / City Street Address / City Fill Out Each Year) Date of Birth Social Security #						

Please See Other Side



STAFF USE
Account #:
DOB:

## **Consent for Healthcare Messages (HIPAA)**

Last Name		First Name	Preferred Name		
Primary Contact Number (cell)		tact Number (cell)	Secondary Contact Number		
Worl	k Numbe	er Job Title	Employer		
EXT	/VOICE	Messages for General Healthcare Informat	ion		
-	•	ssion to FSOBGYN physicians and staff to le arding the following:	eave voicemails or texts on my <i>primary</i> contact		
Y	Ν	Appointments & general information			
Y	Ν	Health information, results, care plan, payment balance			
Y	Ν	Are the above preferences the same for <i>secondary</i> contact number?			
Y	Ν	May we leave a message on the <i>work</i> phone number to call our office?			
SHAF	RING of	Your Health Information and Results			
aive	o nermis	sion to ESOBGYN to share with the person	(s) listed below regarding my health information		

I give permission to FSOBGYN to share with the person(s) listed below regarding my health information including appointment information, test results, diagnoses and care plans.

Name	Relation	Contact Number
Name	Relation	Contact Number

## **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 FSOBGYN 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. I hereby give my consent for my provider to access my medication history via electronic means. I understand that AEL Laboratories will be used for laboratory/pap testing and that should I utilize their patient portal, I may have access to my results before my provider. I understand that my provider will review my results and relay any recommendations to me after those are sent to our office. I understand that there may be a delay between the time the results are on the portal and my physician has those results in my chart.