PATIENT REGISTRATION FORM

DATE

PATIENT ACCOUNT NUMBER

PRACTICE NAME

GREENBRIER OBSTETRICS AND GYNECOLOGY, P.C.

PATIENT INFORMATION *(Please write information about the patient here.)*

Patient's Name (Last, First, Middle Initial) — SEX ☐ Male ☐ Female	Referring Doctor
Patient's Address	Referring Doctor's Address — City — State — Zip
City — State — Zip	Employer's Name — Telephone ( )
Telephone ( ) — MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed — DATE OF BIRTH / / MO DAY YR	Employer's Address — City — State — Zip
AGE — Social Security Number — Driver's License Number	EMPLOYMENT STATUS ☐ Full Time ☐ Retired ☐ Part Time ☐ Not Employed — STUDENT STATUS: If 19 years or older. ☐ Full Time ☐ Part Time ☐ Not a student

INSURANCE INFORMATION *(Please write information about the patient's insurance here.)*

Primary Insurance Company Name ☐ Medical ☐ Dental ☐ W. Comp.	Secondary Insurance Company Name ☐ Medical ☐ Dental ☐ W. Comp.
Insurance Company's Address	Insurance Company's Address
City — State — Zip	City — State — Zip
Insured's ID Number — Group Plan Number	Insured's ID Number — Group Plan Number

POLICYHOLDER INFORMATION

(Complete the information below if the PATIENT is NOT the POLICYHOLDER)

Is the secondary policyholder the: ☐ Patient ☐ Primary Policyholder ☐ Other

(Complete the information below if you checked "Other")

Primary Policyholder's Name (Last, First, Middle int.) — DATE OF BIRTH / / MO DAY YR	Secondary Policyholder's Name (Last, First, Middle int.) — DATE OF BIRTH / / MO DAY YR
Primary Policyholder's Address — SEX ☐ Male ☐ Female	Secondary Policyholder's Address — SEX ☐ Male ☐ Female
City — State — Zip — Telephone ( )	City — State — Zip — Telephone ( )
Employer's Name or School — Telephone ( )	Employer's Name or School — Telephone ( )
Employer's Address	Employer's Address
City — State — Zip	City — State — Zip
Social Security Number — Relationship To Patient ☐ Spouse ☐ Parent Other________	Social Security Number — Relationship To Patient ☐ Spouse ☐ Parent Other________
Employer Plan Coverage ☐ Yes ☐ No — If CHAMPUS: ☐ Active ☐ Retired ☐ Deceased — Branch of Service________	Employer Plan Coverage ☐ Yes ☐ No — If CHAMPUS: ☐ Active ☐ Retired ☐ Deceased — Branch of Service________

RESPONSIBLE PARTY INFORMATION

Responsible party is: ☐ Patient ☐ Primary Policyholder ☐ Secondary Policyholder

(Please complete the information below if the person responsible for paying the bill is not the PATIENT or the POLICYHOLDER)

Responsible Party's Name (Last, First, Middle Initial) — SEX ☐ Male ☐ Female	Social Security No. — Drivers License NO. — Legal Representative ☐ Yes ☐ No
Responsible Party's Address — State — Zip	Employer's Name — Telephone ( )
Telephone ( ) — Relationship to Patient ☐ Spouse ☐ Parent ☐ Parent Other________	Employer's Address — State — Zip

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THE BACK OF THIS FORM. YOU SHOULD READ THOSE TERMS CAREFULLY.

X____________________ Date__________

SIGNED (Patient, or parent if under 18 years of age.)

REV. 10/9

HOW DID YOU HEAR ABOUT US? ______________________________

____

IN CASE OF AN EMERGENCY

WHO SHOULD WE CONTACT?	**NAME** ____________	**DAY** - ( ) ____________
(PLEASE LIST SOMEONE LIVING AT A RESIDENCE OTHER THAN THOSE LISTED ON THE REVERSE SIDE)	**ADDRESS** ____________	**NIGHT**- ( ) ____________
	CITY ____________	**STATE** ______
		RELATIONSHIP ____________

Please remember that insurance is considered a method of reimbursing the patient for the fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. Insurance billing is a gratuity.

I understand if I am unable to keep a scheduled appointment for any reason, I will be charged $25.00 for any appointment not cancelled at least 24 hours prior to the scheduled appointment time. I understand this charge will not be covered by my insurance. I understand this balance will need to be paid prior to my next scheduled appointment. I understand this balance if unpaid, may be assigned to an attorney for collections.

IN ORDER TO CONTROL BILLING COSTS, WE REQUEST THAT ANY CO-PAYMENTS, CO-INSURANCE, OR SELF PAY FEES FOR OFFICE VISITS BE PAID AT THE TIME OF EACH VISIT.

In the event Greenbrier Obstetrics and Gynecology, P.C. assigns my account to an attorney for collection and/or suit, I agree to waive all my homestead deed exemption rights, pay all court cost, all other costs of collection, thirty-three and one third percent (33 1/3 %) attorney fees, and interest at the rate of 1.5% per month on all unpaid balances due after 30 days.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I also understand that it is primarily my responsibility to understand and know all benefits and/or services covered by my insurance plan.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including medicare, private insurance and other health plans to the practice named on the other side of this form.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

THANK YOU FOR YOUR COOPERATION