Laurel Ob-Gyn, P.A.

****PATIENT INFORMATION****

Full legal name _____Date of Birth _____

Social Security # _____Nickname _____

Mailing address _____

Best phone number to contact you _____ Alt _____

May we leave a message about lab results and/or treatment? **YES **NO**

Primary Care Physician and Practice Name_____

Occupation _____Employer name _____

Preferred pharmacy _____Location/Phone #_____

Preferred language _____Race _____ Hispanic/Latino **YES** **NO**

Marital status _____ EMAIL _____

****BILLING INFORMATION****

Responsible party (IF DIFFERENT THAN THE PATIENT) Name, Address, Phone Number:

****SPOUSE/PARENT INFORMATION IF PRIMARY ON ANY INSURANCE POLICY OF YOURS****

Full legal name _____ Date of Birth _____

Address/Phone#_____

Occupation _____ Employer Name/Phone #_____

****EMERGENCY CONTACT INFORMATION****

Person to notify in case of emergency or if we are unable to contact you

Name _____ Relationship _____

Phone number_____Address_____

****Are you authorizing Laurel OB Gyn to release protected health information to the above named individual? (Please circle one) **YES** **NO**

****RELEASE OF INFORMATION (FULL DISCLOSURE ON NEXT PAGE) ****

I hereby consent that below listed are also authorized to receive my protected health information, such as treatment, payment, or lab results. I understand that Laurel OB Gyn will verify the identity of the party listed before information is given.

Name _____Relationship_____

Name _____Relationship_____

Patient signature_____ **Date** _____

I understand that this information will become invalid after 1 year of the date signed.

Laurel Ob-Gyn, PA

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Laurel Ob-Gyn, PA's Privacy Notification. I understand that Laurel Ob-Gyn, PA may use or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my PHI is used and disclosed. If I choose to restrict how my PHI is used or disclosed I understand it must be submitted to Laurel Ob-Gyn, PA in writing. Restrictions are considered on a case-by-case basis.

I have been given a copy of the short form of the "Notice of Patient Information Practices" and understand that I may obtain a copy of the complete version, which is posted in the lobby upon request.

I hereby consent to the use and disclosure of my personal health information for the purposes as outlined in Laurel Ob-Gyn, PA's Privacy Notice. ***I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.***

I hereby authorize Laurel Ob-Gyn to release any PHI regarding my treatment, payment, or lab results. I understand that Laurel Ob-Gyn will verify the identity of the party listed below before any such information is given.

_____ _____

Name *Relationship*

_____ _____

Name *Relationship*

_____ _____

Patient Signature **Date**

With the implementation of our new computer system we now have the ability to confirm your appointments electronically. Please provide the very best phone number for us to call. This number will also be used as the primary contact number for you regarding your health care, lab results, and financial information.

*****IT IS VERY IMPORTANT THAT IF YOU ONLY WANT APPOINTMENT CONFIRMATION CALLS TO THIS NUMBER AND NO HEALTH INFORMATION MESSAGES LEFT THAT YOU CLEARLY CHECK THE BOX PROVIDED**.***

I ONLY WANT APPOINTMENT CONFIRMATION CALLS TO (_____)_____-_____ PHONE NUMBER. I REQUEST NO HEALTH INFORMATION LEFT ON THIS NUMBER.

I HEREBY GIVE LAUREL OB-GYN PERMISSION TO LEAVE A MESSAGE REGARDING MY HEALTHCARE, LAB RESULTS, FINANCIAL INFORMATION, AND APPOINTMENT CONFIRMATIONS ON THE BELOW VOICEMAIL.

(_____)_____-_____ **OR** (_____)_____-_____

_____ _____

Patient signature **Date**

Updated01.25.12

PLEASE READ BELOW AND INITIAL IN THE APPROPRIATE SPACE

By initialing, you agree that you have read and understand the importance of all sections.

AUTHORIZATION FOR TREATMENT

I HEREBY CONSENT TO MEDICAL TREATMENT, DIAGNOSTIC PROCEDURE AND INJECTIONS BY PROVIDERS AND STAFF OF LAUREL OBGYN. I UNDERSTAND THAT DIAGNOSTIC PROCEDURES MAY INCLUDE BUT ARE NOT LIMITED TO, LAB TESTS ON BLOOD, URINE, AND TISSUE. I UNDERSTAND I MAY BE ASKED TO UNDERGO DIAGNOSTIC RADIOLOGY PROCEDURES INCLUDING, BUT NOT LIMITED TO, ULTRASOUND. I UNDERSTAND I HAVE THE RIGHT TO ASK QUESTIONS ABOUT MY TREATMENT AND OR PROCEDURES AND I AGREE TO NOTIFY MY PROVIDER OF MY CONCERNS.

_____ INITIALS

Important information regarding your specimen sent out of the office.

Laurel OB-Gyn is in agreement to send all Pap smear and biopsy specimens to Solstas Lab. Please be aware that Solstas does bill separately for processing your specimen. Laurel OB-Gyn is not affiliated with Solstas Lab, we are two separate companies. It is your responsibility to be aware of your insurance benefits and to know if they are in your network. If your insurance company is not in network with Solstas Lab please let your nurse know so she can fill out the proper paperwork for another lab in your network.

_____ INITIALS

Appointment Policy

We understand that sometimes your day may not go as planned and you may miss your appointment with us. However, effective 5/1/2015, Laurel OB-GYN has implemented the following policy. Patients will be asked to give at least 24 hours notice for any appointment cancellations. This is to give other patients the opportunity to be scheduled in that time slot. Patients that do not give at least 24 hours notice or that do not show up for their appointments will be subject to a $50.00 fee. In the event that not keeping your appointments becomes an issue, patients may be dismissed from the practice.

_____ INITIALS

Financial Policy

By initialing here you are consenting that you have read and understand our financial policy, located in your new patient packet or on the front of your clipboard. As of 5/1/2015, patients that do not give at least 24 hours notice to cancel or reschedule their appointments or do not show up for their appointments will be subject to a $50.00 fee.

_____ INITIALS

Code of Conduct

Laurel OB-Gyn, PA takes pride in personal traditional care. We aim to treat all of our patients with respect and dignity at all times. We also expect the same from our patients. Angry outbursts, aggressive or violent type behavior or inappropriate language will not be tolerated. Failure to comply with this may result in termination of our patient-physician relationship.

_____ INITIALS

Prescription Refills

Refill request called in after 4:00pm may not be refilled until the next business day. The on-call physician will not refill any birth control or controlled substances after hours.

_____ INITIALS

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_____ INITIALS

As of 3/1/2016, we will require a valid credit/debit card to be kept on file. We do this for easier, more convenient payments of future charges and to secure your appointments. Your credit card details and other billing information are stored in compliance with the highest safety and security standards. Laurel OBGYN, P.A. follows these regulations to help protect the personal data of our patients.

I, _____, certify that I am authorized to use this credit card. By signing below, I authorize Laurel OBGYN, PA to charge the credit card on file for payment of services provided, including charges for any appointments canceled without a 24-hour notice.

Patient Signature: _____ **Date:** _____

I understand that this information will become invalid after 1 year of date signed.