Gynecological & Obstetrical Associates

Patient Name _____ _____ Date of Birth ____/____/____
Middle Initial

Address _____ Apt_____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( ) _____

Marital Status [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Email Address _____

Social Security # _____-_____-_____ Patient Employed [ ] Yes [ ] No

Employer _____ Work Phone ( ) _____

Referred By _____

INSURANCE INFORMATION

Primary Insurance _____ [ ] PPO [ ] HMO

Policy Holder _____ Date of Birth _____/_____/_____

Relation to Subscriber [ ] SELF [ ] SPOUSE [ ] PARENT [ ] OTHER _____

Member ID _____ Group # _____

Secondary Insurance _____ [ ] PPO [ ] HMO

Policy Holder _____ Date of Birth _____/_____/_____

Relation to Subscriber [ ] SELF [ ] SPOUSE [ ] PARENT [ ] OTHER _____

Member ID _____ Group # _____

EMAIL: FRONTDESK@GYNOB.NET

I authorize the release of all medical information required in the course of examination or treatment to any insurance group or carrier which I may have in support of benefits to which I may be entitled. I further direct that payment of my benefits under such insurance due me for services rendered are hereby assigned to GYN/OB Associates. I further recognize and accept personal responsibility for full payment of the charges for professional services rendered to be at my request. I accept responsibility for any services my insurance does not cover. Requests to amend information must be made in writing. Requests to access records must be made in writing. There will be a charge for any summaries of records.

Signature (Patient/Guardian) _____ Date _____

CONTINUED ON BACK →

Gynecological & Obstetrical Associates

Rebecca Weprin, MD Shelia Chhutani, MD David Lombardi, MD
Laura Rosenfield, MD Clara Telford, MD

I, _____, hereby authorize Gynecological and Obstetrical Associates to release any information pertaining to my medical care to the following person(s): (For example: Names of parents, guardian, spouse, children, close friend, etc.)
Please list below:

_____ _____

[ ] I do not wish to have my medical information released to anyone.

Do you have a phone number where your doctor or nurse may leave a message with specific medical results and information?

[ ] No
[ ] Yes, leave messages and/or text this phone number _____
[ ] Yes, ok to send email regarding appointments. _____

Emergency Contact _____

Relationship _____ Phone ( )_____

This information will remain in effect unless you inform us of additions/deletions.

_____ _____
Patient Signature Date

_____
Witness (Office Staff ONLY)

8160 Walnut Hill Ln, Ste 100 Dallas, TX 75231 ◊ Phone: (214)369-1203 ◊ Fax: (214)369-0586

Gynecological & Obstetrical Associates
Financial Policy

Thank you for choosing our office as your health care providers. We are committed to providing excellent health care service. As part of our professional relationship, it is important that you have an understanding of our financial policy.

ALL PATIENTS MUST READ AND SIGN THIS FORM PRIOR TO RECEIVING SERVICES.

- **IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH YOUR MOST CURRENT INSURANCE INFORMATION.** If you fail to provide accurate information in a timely manner, your insurance company may deny the claim or we may not be able to file it due to filing deadlines. If the claim is denied, you **WILL BE FINANCIALLY RESPONSIBLE FOR YOUR SERVICES.**
- Failure to keep your account balance current may require us to cancel/reschedule your appointment.
- We must emphasize that as, medical providers; our relationship is with you and not your insurance company. Your insurance is a contract between you and your insurance company and possibly your employer. It is your responsibility to know and understand the level of benefits of your insurance plan
- We may accept assignment of insurance but please be aware that some or perhaps all of your services provided may not be covered in full by your insurance company. **YOU ARE FINANCIALLY RESPONSIBLE FOR SERVICES NOT COVERED BY YOUR INSURANCE.**
- Before receiving services, you **MUST VERIFY** that we are **PARTICIPATING PROVIDERS IN YOUR PARTICULAR PLAN.**
- **Copayments, coinsurance and/or deductibles are due at the time of service.** We will estimate the amount you owe based on the information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim, regardless of our estimation.
- We will send a statement (to the billing address you provide) notifying you of any balances you owe. If you have any questions it is your responsibility to contact this office within 30 days of the statement date.
- If you submit payment by check and the bank returns the check unpaid for any reason, we will add a **$35 returned check charge** to your account.
- A **NO SHOW** fee of **$50** if you fail to cancel or reschedule your appointment at least **48 hours** prior to your appointment date.
- **There is a $25 fee for *each* set of forms being completed by our office for FMLA or other leave of absence.** (Please allow 10 business days for paperwork to be processed in our office).

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

We accept cash, checks. Master Card, Visa, Discover & American Express.

I have read and understand this financial policy.

Responsible Party Signature_____Date_____

Print Patient Name _____DOB: _____