7205 West Center Road, Suite 200

Omaha, Nebraska 68124

(402) 397-6600

Patient Registration – Mid City OB-GYN, P.C.

Preferred PHARMACY_____Address_____Phone(___)_____

PATIENT LEGAL NAME_____

(Please Print) (Last) (First) (Middle)

Preferred Name_____ Birth Date_____ SS#_____

Race/Ethnicity_____ Marital Status (W) ___ (M)____(D)___ (S)___

Address_____City_____State_____Zip_____

Phone Home(____) _____Work(____) _____Cell(____) _____

Preferred contact number (circle one) Home Work Cell Preferred contact method (circle one) Voice Text Email

Email_____

Emergency Contact_____Relation_____Phone(___)_____

Your Employer: _____

Referred by: Family ____Friend ____Physician ___Website____ Other_____ (please choose one)

Referring Physician_____Address_____Phone(___)_____

Family Physician_____ Address_____ Phone(___)_____

<u>If covered under spouse's or parent's insurance Policy Holders</u>

Name_____Relation_____

Phone(____) _____DOB_____ SS#_____

Address if different than patient_____

<u>Insurance Information (IF NO CARD PROVIDED)</u>

Primary Ins. Co. _____

Policy # _____ Group# _____

Secondary Ins. Co. _____

Policy #_____Group #_____

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CONSENTS OF Mid-City OB-GYN, P.C.

CONSENT TO TREAT: I voluntarily consent to medical treatment and diagnostic procedures by Mid-City OB-GYN, P.C. I consent to the testing for infectious diseases, such as but not limited to syphilis, hepatitis, HIV/AIDS, and testing for drugs if deemed advisable by my physician.

> HIV(Human Immunodeficiency Virus) is the virus that causes AIDS (Acquired ImmunoDeficiency Syndrome). A positive HIV test means that HIV antibodies have been detected, and that the individual has probably been infected with HIV. A negative test means that the antibody to HIV has not been detected, and the individual has probably not been infected with HIV.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

CONSENT TO E-PRESCRIBING PBM: I hereby authorize that Mid-City OB-GYN, P.C. can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

ACKNOWLEDGMENT OR RECEIPT OF NOTICE OR PRIVACY PRACTICES: I acknowledge that I was provided with the Notice of Privacy Practice of the Medical Practice named at the top of this page.

AUTHORIZATION FOR RELEASE OR INFORMATION: I hereby authorize the release of my medical records by Mid-City OB-GYN, P.C. to my attending physician, hospitals and third party payer (whether an insurance co., government agency, employer or self-insurance employer or utilization review organization).

ASSIGNMENT OF BENEFITS: I hereby assign to said physician all right, title and interest to any benefit payable for medical coverage. I direct that such benefits be paid directly to said physician and I will be responsible for any charges accrued and not paid by the insurance company. I understand I am responsible for all co-pays, deductibles, co-insurance and any non-covered services.

CONSENT FOR SHARING of PROTECTED HEATLH DATA and INFORMATION: Please list the names and relationship of family members or other persons, if any, whom we may inform verbally and/or copy of records to about your general medical condition and your diagnosis (including treatment, payment, and health care operations).
1._____ 2._____

TEST RESULTS AND CONFIDENTIAL MESSAGES: Can confidential messages (i.e. appointment reminder, test results, etc.) be on your telephone answering machine or voicemail? I am fully aware that a cell phone is not a secure and private line.

YES_____ NO_____

Patient's Name (PRINT) _____

_____ _____ _____
Signature of Patient or Responsible Party Responsible Party Relationship to Patient Date

For Practice Use Only: Witness Signature of Practice Employee
_____Date_____
Doctor_____ Acct. #_____

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FINANCIAL POLICY OF MID-CITY OB-GYN, P.C.

Thank you for choosing Mid-City OB-GYN, P.C. The following is a statement of our Financial Policy. All patients must accept our Financial Policy before receiving treatment. Please understand that full payment of your bill is considered a part of your treatment.

METHOD OF PAYMENT: We accept cash, checks, and all major credit/debit cards. A payment plan may be arranged on individual basis with the Financial Consultant in our office.

REGARDING YOUR INSURANCE: As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of our claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. We cannot bill your insurance company unless you give us your complete insurance information. Without complete insurance information you will be considered Self-Pay. It is your responsibility to know your insurance benefits; it may not cover all of the services provided to you.

DEFINITIONS

- **COPAYMENTS:** A fixed dollar amount set by your insurance contract that is to be paid at the time of an office visit. This amount is usually between $10.00 and $80.00.
- **DEDUCTIBLE:** An annual dollar amount established by your insurance plan that is deducted from insurance benefits. This amount is your obligation and must be paid prior to health care services.
- **CO-INSURANCE:** A percent set by your insurance plan that is deducted from insurance benefits. This percent usually ranges between 10% and 30% and is your obligation to pay.

REGARDING INSURANCE PLANS where we are a participating provider: All copays are due PRIOR to treatment.

SELF-PAY PATIENTS: Require $100.00 down payment PRIOR to treatment. You may receive a 20% discount if Paid in Full the day of the appointment, with the understanding that charges may be pending from the lab or physician's dictation other wised mentioned at the time of payment.

COLLECTIONS: We reserve the right to forward your account to a collection agency if it is determined to be uncollectible. Signature implies receipt and understanding of our financial policy.

_____	_____	_____
Patient or Responsible Party	Responsible Party Relationship to Patient	Date

For Practice Use Only:

Patient Name (Print) _____

Acct. #_____