OB-GYN Associates

101 Holbrook Street
Danville, VA 24541
Phone: (434) 792-7765
Fax: (434) 793-4061

PATIENT INFORMATION

Name:	Race/ Ethnicity:
Address:	Marital Status:
City:	Date of Birth:
State: Zip:	Social Security #:
Home Phone#:	Employer/School
Work Phone#:	Full -Time ____ Part-Time ____
Cell Phone#:	Employer Address:
Email Address:	
Emergency Contact: Relationship:	Phone #:

PARENT OR SPOUSE INFORMATION

Name:	Date of Birth:
Address:	Social Security#:
	Full-Time_____ Part-Time___
City:	Employer:
State: Zip:	Employer Address:
Home Phone #:	
Cell Phone #:	Work Phone#:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
ID#:	ID#:
Group Number:	Group Number:
Group Name :	Group Name:
Address:	Address:
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth: Relationship to Patient	Subscriber Date of Birth: Relationship to Patient:

This is an agreement between OB-GYN Associates of Danville and the responsible party:

Late Policy: All efforts are made to keep our physicians schedule on time; therefore, if you are more than 15 minutes late, every effort will be made to fit you into the schedule; however, there is no guarantee that you will be seen. If the providers' schedule is full you will be asked to reschedule your appointment.

Co-Payment: All co-payments are required at the time of service you maybe asked to reschedule your appointment if you do not pay your co-payment.

Payment options if you do not have proof of insurance or have no insurance: You are responsible for payment by cash, check or credit card on the day of service. On bills with extensive procedures and by approval of our billing department, you may pay 50% on the date of service and the balance in 30 days.

Payments: Unless other arrangements are approved by the billing department, the balance on your statement is due on the due date posted on your statement. If your account becomes past due, you agree to pay all collection and court fees that are incurred.

Returned Checks: There is a $35.00 fee for any checks returned by the bank.

Signature:_____ Date:_____

Patient or Parent of Minor

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FINANCIAL POLICY

Welcome to OB/GYN Associates of Danville. Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal care needed to maintain/restore your health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to speak with our billing staff.

Please present your current insurance ID card at each visit so we can avoid filing errors. If you do not have your current insurance card at the time of your visit we may have to reschedule your appointment. If at any time your insurance should change, especially during pregnancy, our office must be notified immediately of the change to accurately file claims. IF WE DO NOT RECEIVE YOUR CURRENT INSURANCE INFORMATION AND CANNOT FILE THE CLAIM IN THE NECESSARY TIME AS MANDATED BY YOUR INSURANCE COMPANY, YOU WILL BE RESPONSIBLE FOR ALL CHARGES. In the event we do not participate with your insurance plan you may be responsible for the entire bill.

As a service to you, our office makes every reasonable effort to obtain payment according to your coverage. Regardless of the type of insurance you have, you are ultimately responsible for paying your medical bills. If your insurance company rejects the claim or denies payment, the office will bill you after 30 days for those charges. It is, at all times, your responsibility to know your benefits, follow up on all requests from your insurance regarding claims and to question your insurance company about any unpaid claims. Unresolved balances may be placed with an outside collection agency and may also be subject to finance charges, attorney fees and collection agency fees.

If you need to cancel an appointment we ask for you to give us a 24 hour notice, or we reserve the right to charge you for your missed appointment. We also reserve the right to dismiss you from the practice if you have three visits that have not been cancelled with a 24 hour notice.

All co-payment and deductible amounts are due and should be paid at time of service. This policy is in accordance with legal requirements for collecting patient responsibility amounts. If you are unable to pay your co-payment we may ask that you reschedule your appointment.

The responsibility of payment for services rendered to any dependent children whose parents are divorced or separated is with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office.

Failure to provide necessary referrals and/or authorizations will result in all charges for services becoming the sole responsibility of the patient/responsible party.

Our practice accepts Visa, MasterCard, Discover, American Express and debit cards for your convenience. We also accept personal checks (not starter checks) and cash. In some cases you may apply for CareCredit.

Authorization:
I agree to abide by the terms of the above financial policy and accept responsibility for any balance not covered by my insurance company(s). I authorize my insurance company(s), attorney or other parties to pay OB/GYN Associates of Danville and/or provide any information regarding payment of my bill. If my account becomes delinquent, I agree to pay all costs incurred in collecting the account, including any necessary attorney fees.

I authorize OB/GYN Associates of Danville to administer medical care as is necessary, including allowing release of records or medical reports on my physical condition to any party involved in my treatment.

I agree that I have fully read and comprehend the statements made above in this financial policy and agree to all terms.

Signature:_____ Date:_____

Print Name:_____

Relationship to Patient:_____

Office Use Only: Entered by:_____ Date:_____Chart#:_____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, OB-GYN Associates of Danville may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review and/or obtain a copy of the Notice of Privacy Practices prior to signing this consent.

With my consent OB-GYN Associates of Danville may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including normal laboratory results.

With my consent OB-GYN Associates of Danville may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder and patient statements.

The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to OB-GYN Associates of Danville use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, OB-GYN Associates of Danville may decline to provide treatment to me.

_____ _____

(Signature of patient or Legal Guardian) (Relationship to Patient)

_____ _____

(Patient's Name) (Date)

*Revised 9/23/13

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PLEASE LIST THE NAME(s) OF ANY PERSON(s) THAT YOU WOULD LIKE TO HAVE ACCESS TO YOUR HEALTH CARE INFORMATION, APPOINTMENT DATES, ETC.

IF THEIR NAME IS NOT LISTED BELOW, THEY CANNOT ACCESS ANY OF YOUR INFORMATION.

IF YOU WOULD NOT LIKE ANYONE TO HAVE ACCESS TO YOUR INFORMATION, PLEASE WRITE "SELF ONLY" BELOW.

_____

_____

_____

_____

_____ _____

PATIENT SIGNATURE **DATE**

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Date:_____

Name:_____Date of Birth:_____

Reason for Visit:_____

Past Medical History (Medical issues that you may have now or have been treated for in the past):

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Past Surgical History:

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Current Medications (Please list name, dose, frequency taken):

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Allergies:

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Pregnany History (Include miscarriages, terminations and deliveries. Also vaginal delivery or cesarean, birth weight, and any complications with pregnancy or delivery):

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

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GYNECOLOGICAL HISTORY:

First day of last menstrual period:_____

Circle if YOU have had now or in the past:

Sexually Transmitted Disease / Endometriosis / Ovarian Cysts / Abnormal Pap Smears / Fibroids

If not menopausal, what method of birth control do you use?_____

SOCIAL HISTORY: (Circle all that apply)

Married / Single / Divorced / Widowed

Smoke Cigarettes: Yes / No Packs per Day:_____

Alcohol: Yes / No Drinks Per Week:_____

Recreational Drug Use: _____

Sexual Orientation: Heterosexual / Homosexual

Physical Abuse / Sexual Abuse / emotional abuse

FAMILY MEDICAL HISTORY (example: heart disease, cancer, diabetes, high blood pressure, etc.)

Mother:

Father:

Brothers:

Sisters:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Children:

PREVENTATIVE HEALTH (Please include date and result of last test, indicate not done if never done):

Colonoscopy: _____

Mammogram: _____

Pap Smear: _____

Bone Density: _____

Cholesterol Screening: _____

Thyroid Screening: _____