

PATIENT CONSENT & RELEASE

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to Seattle OB/GYN Group. I authorize the release of any information required to process my claim. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections I will be responsible for all collection fees, collection costs, attorney fees and court costs involved with my account. Initial _____

FINANCIAL POLICY

Our office is committed to providing quality and cost-effective healthcare to our patients. In today's insurance environment it is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment with us. It is your responsibility to understand the limits and restrictions affecting coverage for services provided by our specialty. If your insurance company requires you to use a specific lab, it is your responsibility to notify us. Insurance reimbursement is a contract between you and your insurance company. As a courtesy to you we will file all primary and secondary claims for you. We will require a current copy of your insurance card in order to do this and will need to be informed of any change in insurance status. You will be responsible for all co-pay, deductibles, and co-insurance amounts not covered by a secondary insurance policy along with the entire amount of any non-covered service. We appreciate payment for services at the time they are rendered. For your convenience, we accept cash, personal checks, Visa, and MasterCard. If your personal check is returned by the bank due to *Insufficient Funds*, a fee will be charged. We also realize that healthcare is sometimes an unplanned event, so we will attempt to accommodate your personal needs as circumstances require. Patients who do not have insurance coverage (or proof of coverage) or who choose to pay for non-covered services are expected to pay in full at the time of service. If you cannot pay the full amount, then you must make satisfactory payment arrangements with our business office prior to receiving services. We charge for the completion of FMLA and Disability forms. In order to best meet your needs, please call our business office at (206) 682-5843 with any questions you may have regarding our financial policy and procedures. Initial _____

PREVENTIVE CARE

Your health insurance plan may not provide coverage for preventive services. It is important that you contact your insurance provider to determine if your plan offers benefits for this service and what their scheduling guidelines are for it. We use industry standard codes and guidelines to submit claims to the insurance companies based on the primary focus of the exam and documentation in the patient's medical record. Current laws regarding fraud and abuse with billing procedures prohibit us from changing the procedure codes and/or diagnosis codes in order to get the claim paid by the insurance company. DSHS does not pay for annual exams, payment is your responsibility. Initial _____

NOTICE OF INFORMATION PRACTICES – ACKNOWLEDGMENT

We keep a record of the healthcare services we provide you. You have the right to know how we use and disclose information about you. This is provided in our *Notice of Health Information Practices*. You may also ask to see and copy your records. If you would like more information, please call and ask for our Medical Records Department. Initial _____

AUTHORIZATION TO SHARE HEALTH CARE INFORMATION

You may share the following healthcare information with: Partner Family Other: Relation: _____

Name: _____ Phone: (____) _____

Please check all that apply:

All healthcare information in my records Insurance and billing information

Healthcare information in my medical record relating to the following treatment: _____

Other (appointments, test results, etc.) _____

DO NOT share any healthcare information with: _____

Initial _____

I have read and understand the above policies.

Patient Signature _____ Date: _____
(or legally authorized individual's signature)

Printed Name if signed on behalf of patient _____ Relationship _____

SEATTLE OB/GYN GROUP

1101 Madison, Suite 950
Seattle, WA 98104

SEATTLE GYN CLINIC

801 Broadway, Suite 623
Seattle, WA 98122

Patient Information

Date ____/____/____

Patient Name _____
Last First M.I. Nickname

Marital Status: ____ Married ____ Single ____ Divorced ____ Other Date of Birth ____/____/____

Social Security Number _____ - _____ - _____

Patient Address _____
Street City State Zip Code

Primary Phone (____) _____ Home__ Cellular__ Work__ May leave detailed message __

Secondary Phone (____) _____ Home__ Cellular__ Work__ May leave detailed message __

E-mail Address _____ Preferred Pharmacy _____

Employer _____ Occupation _____

Partner's Name _____ May leave personal health Information__

Partner's Phone (____) _____ Home__ Cellular__ Work__

Emergency Contact (person not living at same address)

Name _____ Relation _____ Phone (____) _____

How did you hear about us? ____Physician ____Friend/Family ____Yellow Pages ____Web site ____Insurance

INSURANCE INFORMATION:

In order to bill your insurance(s) we must have a copy of your insurance card(s) presented at each visit.

Insurance Company _____	Effective Date of Insurance _____
Group # _____	Identification # _____
Is patient the subscriber? Yes__ No__ If no, then: Subscriber's Name _____	
Subscriber's Soc Sec # _____	Subscriber's Date of Birth ____/____/____
Subscriber's Employer _____	Relationship to Patient _____

Secondary Insurance Company _____	Effective Date of Insurance _____
Group # _____	Identification # _____
Is patient the subscriber? Yes__ No__ If no, then: Subscriber's Name _____	
Subscriber's Soc Sec # _____	Subscriber's Date of Birth ____/____/____
Subscriber's Employer _____	Relationship to Patient _____

(please turn over)