

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. Insurance reimbursement is a contract between you and your insurance company. 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 of services you receive. If your insurance company requires you to use a specific laboratory, it is your responsibility to notify us. 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(s) 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 coinsurance amounts not covered by your insurance policy along with the entire amount of any non-covered service. Patients who do not have insurance coverage (or proof of coverage) or who choose to pay for 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. 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. Fees may also be assessed for failure to keep scheduled appointments, or failure to cancel with at least 24 hours notice. We realize that healthcare is sometimes an unplanned event, so we will attempt to accommodate your needs as circumstances require. 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 RELEASE HEALTH CARE INFORMATION

May leave detailed message at: Home Work Cellular phone With Spouse/Partner

I authorize Seattle OB/GYN Group to share:

- ALL healthcare information
- Other (appointments, test results, etc.) _____

With the following individual(s); Name: _____ Relationship: _____

Name: _____ Relationship: _____

DO NOT SHARE any healthcare information with: _____

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 GROUP1101 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

Date of Birth: ____/____/____

Social Security Number: ____-____-____

Patient Address: _____
Street /Apt # City State Zip Code

Primary Phone: (____) _____ Home__ Cellular__ Work__

Phone: (____) _____ Home__ Cellular__ Work__

Phone: (____) _____ Home__ Cellular__ Work__

E-mail Address: _____

Employer: _____

Partner's Name: _____

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 _____