River City OB/GYN, P.C.
Patient Registration Form

PATIENT INFORMATION

Patient Name:

_____ Sex: ☐ Female ☐ Male

(First) (Middle) (Last)

Marital Status: ☐Married ☐Divorced ☐Single ☐separated ☐Domestic Partner ☐Widowed

Date of Birth: _____/_____/_____ Social security Number: _____-_____-_____

Mobile Number: (_____)_____-_____ Email Address:_____

Home Number: (_____) _____-_____ Work Number: (_____) _____-_____

Home Address: _____

City: _____ State: _____ Zip: _____

How did you hear about River City OB/GYN:_____

ETHNICITY/ RACE: ☐ Hispanic or Latino ☐ Asian ☐ White or Caucasian ☐ American Endian or Alaska Native

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Patient declines to specify

Emergency Contact:

Name: _____ Relationship to patient: _____

Phone:_____

RESPONSIBLE PARTY (if other than patient)

Guarantor's Name: _____ Phone Number: _____

Address: (If different from Above)

_____City:_____State:_____Zip:_____

Patient Relation to Guarantor: _____ Guarantor's Employer:_____

Employer Address: _____City:_____State:_____Zip:_____

Guarantor Social Security: __ __ __- __ __- __ __ __ __ Guarantor D.O.B: _____

Insurance Information (you may loave blank if you can present your card to the receptionist)

PRIMARY

Name of Insurance Company: _____ Policy Holder: _____

ID Number: _____ Group Number: _____

SECONDARY

Name of Insurance Company: _____ Policy Holder: _____

ID Number: _____ Group Number: _____

I hereby authorize River City OB/GYN, P.C., to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to River City OB/GYN, P.C. of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient's Signature (or responsible party) _____Date: _____

PATIENT ACKNOLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize River City OB/GYN, P.C., to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to River City OB/GYN, P.C. of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

_____ Date: _____

Patient's Signature (or responsible party)

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

SPECIFIC INFORMATION RELEASE (if applicable)

I request and authorize River City OB/GYN, P.C. to disclose protected health care information to the individual(s) listed below.

Name: _____ Contact #: _____

Name: _____ Contact #: _____

Name: _____ Contact #: _____

NOTICE OF PRIVACY PRACTICES (HIPPA)

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____ Date: _____

Patient's signature (or responsible party)

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to River City OB/GYN, P.C. using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to River City OB/GYN, P.C. using or disclosing my protected health information for treatment activities provided by another provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operation including quality assessment and reviewing the competence of health care professionals.

_____ Date:_____

Patient's signature (or responsible party)

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

River City OB/GYN Cancellation/No Show Policy

1. Cancellation/No Show for Scheduled Appointment:
   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a Thirty-Five Dollar ($35) fee; this will not be covered by your insurance company. This appointment will also be marked as a No Show since adequate cancellation notice was not given. We will limit the number of No Shows or late cancellations allowed per patient. If you are a No Show three (3) times, we will no longer schedule appointments for you at our practice.

1. Late Arrival for Scheduled Appointments:
   We understand that delays can happen; however, we must try to keep the other patients and doctors on time. **If a patient arrives 15 minutes past their scheduled time, we will have to reschedule the appointment.**

_____
Printed Name

_____
Patient Signature or Guardian Signature

_____/_____/_____
Date