University Park Obstetrics and Gynecology, LLC -Shawn Stephens, M.D.

(Please Print)				Today's Date: / /
Patient's last name:			First:	Middle:
Birth date: / /	Age:		Marital status (circle one)	Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?			
Street address:		P. O. Box:		Email Address:
City:	State:		ZIP Code:	SS#:
Cell Phone:	Home Phone:			Work Phone:
Occupation:	Employer:			
How did you hear about our office?	❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family ❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	Describe:

Race: ❑ African American/Black ❑ Asian ❑ Caucasian/White ❑ Pacific Islander/Native Hawaiian ❑ Hispanic/Latino ❑ American Indian/Alaskan Native ❑ Other

Ethnicity: ❑ Hispanic/Latino ❑ Non Hispanic or Latino Preferred Language ❑ English ❑ Spanish ❑ Other___________

INSURANCE INFORMATION

(Please give your insurance card and photo identification to the receptionist.)

Please indicate primary insurance:					
Insurance ID#:		Group #:		Co-pay: $	
Subscriber's name:				Subscriber's Birth date: / /	
Subscriber's S.S. #:	Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of secondary insurance:		Subscriber's name:			
Group #:		Policy #:			
What Laboratory does your insurance require you to use?					

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		
Home phone #:	Work phone #:	Relationship to patient:

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

May we call you at home?	Yes	No	May we send a yearly recall to your home?	Yes	No
May we leave a message at your home?	Yes	No	May we call you at work?	Yes	No
May we leave a message on your cell?	Yes	No	I authorize University Park OBGYN to speak with ________________________ regarding my healthcare/PHI . (relationship to you) ____________________		

I acknowledge and agree to adhere to the Notice of Privacy Practices as required by federal and state guidelines. I have been provided a copy of the Notice of Privacy Practice and understand that I may request and review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims.

Patient/Guardian signature	*Date*

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I have completed this form and certify that I am the patient or duly authorized agent of the patient. I authorize the providers of University Park Obstetrics and Gynecology, LLC to provide medical care and treatment for me. I authorize University Park Obstetrics and Gynecology,LLC to obtain verification of my medication/prescription history in order to provide continuity of care. I authorize release of my medical information as directed by my physician for outside referrals to specialists, hospitals, laboratories and others as necessary for my continued care.

I hereby authorize payment of benefits to be made directly to University Park Obstetrics and Gynecology, LLC and/or any of the providers individually. I understand, as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service or statement and billing fees may be assessed. I understand that any overpayment I make will be refunded if the credit amount is over $14.99. Otherwise, the credit will be held for 18 months for future balances unless a request for refund is received.

Patient/Guardian signature	*Date*