FOR OFFICE USE:

Copy of Driver's License: ☐
Copy of Insurance Card(s): ☐

Patient Information

Name (Last, First):		Who referred you to our practice?
Date of Birth:	Age:	SS#:
Address:		City, State, Zip Code:
Patient Home Phone:		Patient Cell Phone:
Patient Employer:		Patient's Occupation:
Patient Business Address:		City, State, Zip Code:
Patient Work Phone:		
Patient Email:		
In Case of Emergency /Spouse / Parent/ Guardian (If under age 18): (Circle)		Phone Number:
Address:		City, State, Zip Code:
Primary Insurance		Secondary Insurance
Insured Party ID#:		Insured Party ID#:
Group ID#		Group ID#
Name of Insured:		Name of Insured:

**** Payment is due at the time of service.****

Assignment and Release: I, the undersigned, certify that I (or my dependent) have insurance coverage as stated above and assign to Isis Ob/Gyn, LLC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am fully responsible for all charge not paid by my insurance company. I hereby authorize this practice to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submission. I fully understand that any outside lab work performed will be billed by that lab, independently.

Patient's Signature:	Date:
Guardian Signature (if under age of 18):	Date:

HIPPA – Patient Consent Form

PATIENT CONSENT FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient Name: ____ Date Of Birth: ___________________________

Previous / Other Names: _____________________________________ __ SSN: ___________________________________

I understand that the patient's health information is private and confidential. I understand that Isis Ob/Gyn, LLC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Isis Ob/Gyn may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosure of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission.

Isis Ob/Gyn has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I will have a right to read the "Notice" before signing this agreement.

Isis Ob/Gyn may update this "Notice of Privacy Practices". If I ask, Isis Ob/Gyn will provide me with the most current "Notice of Privacy Practices". Under the terms of this consent, I can ask Isis Ob/Gyn, LLC to limit how the patient's personal health information is used or disclosed to carry out treatment, payment, or health care operations understand that Isis Ob/Gyn does not have to agree to my request. If Isis Ob/Gyn does agree to my request, I understand that they would follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

1. Signing and dating a form that Isis Ob/Gyn can give me a called "Revocation of Consent for Use and Disclosure of Health Care Information", or
2. Writing, signing, and dating a letter to Isis Ob/Gyn. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

If I revoke this consent, Isis Ob/Gyn, LLC does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of Isis Ob/Gyn's "Notice of Privacy Practices". My signature means that I agree to allow Isis Ob/Gyn to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

Patient/Legally-Authorized Signature: ____Date: ___________________

Relationship to Patient if signed by anyone other than patient: ____