

# Bergen Ob-Gyn

PROGRESSIVE WOMEN'S MEDICINE. PERSONALIZED, COMFORTABLE CARE.

Welcome to our office! Please complete both sides of this form.

## Patient Information

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(First) (Middle) (Last)

Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Minor  Single  Married  Divorced  Separated  Widow

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_

Phone number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Referred to us by: \_\_\_\_\_

## Employer Information

### Patient Information:

Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

### Spouse/Parent Information:

Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

## Insurance Information

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship:  Self  Spouse  Other: \_\_\_\_\_

Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Policy #: \_\_\_\_\_

## Acknowledgement of the Receipt of Notice of Health Information Practices

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Bergen Ob/Gyn Associates is furnishing you with a written notice which provides information about how our office may use and/or disclose protected health information for treatment, payment, health care operations and as otherwise allowed by law. By signing below, you acknowledge that you have received a copy of this office's Notice of Health Information Practices.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Financial Policy Notice**

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility.

Insurance payments are based on rates that insurance companies arbitrarily determine to be usual and customary. Often times, insurance payments are not 100% of the fees charged. It is your responsibility as the patient to know your insurance coverage benefits and for paying any amount not covered by insurance. All co-payment, co-insurance and deductible amounts are due and payable at the time services are rendered. If your account becomes delinquent, you will be responsible for any and all collection expenses, interest (1.5% per month) and legally allowed fees including, but not limited to, court costs, legal fees and penalties.

It is understood that temporary financial problems arise; you are encouraged to contact us promptly for assistance in the management of your account. If you have any questions regarding the above information, please do not hesitate to ask.

I have read the above and agree to this office's financial policy. \_\_\_\_\_  
(Please initial)

**Cancellation Policy Notice**

Bergen Ob/Gyn Associates understands that personal situations arise and you may need to cancel your appointment. We kindly request a 24 hour notice of cancellation. Not showing for an appointment or failing to courteously notify our office prevents us from seeing other patients who have sudden medical problems which require medical intervention. If you are running late to a scheduled appointment, please contact our office as soon as possible. The staff will assess the situation to try and accommodate you. Keep in mind, the appointment may need to be delayed or rescheduled.

I have read the above and agree to this office's cancellation policy. \_\_\_\_\_  
(Please initial)

**Consent for General Patient Care and Assignment of Benefits**

I have read the above policies and understand my responsibilities as a patient. I hereby authorize Bergen Ob/Gyn Associates, including physicians and employees, to provide medical care to me and agree to pay all fees and charges for such treatment. I authorize Bergen Ob/Gyn Associates to furnish all information, including protected health information, to insurance carriers and other health care providers concerning my illness and treatments, and assign all payments for medical services rendered to be made directly to Bergen Ob/Gyn Associates.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to Treat a Minor (only if applicable)**

I, \_\_\_\_\_, give Bergen Ob/Gyn Associates my permission to examine and  
(Parent/Guardian)  
treat \_\_\_\_\_.  
(Minor)

Authorization to treat minor: \_\_\_\_\_  Mother  Father  Guardian  
(Signature)