

Date \_\_\_\_\_

Name \_\_\_\_\_ Birth date \_\_\_\_\_ SS# \_\_\_\_\_  
First MI Last

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_ Home Phone \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse Name \_\_\_\_\_ Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

Name of nearest relative \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**RESPONSIBLE PARTY**

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

Primary care physician \_\_\_\_\_ Phone \_\_\_\_\_

**It is the patient's responsibility to bring any referrals from their primary care physician.**

**INSURANCE INFORMATION**

**PRIMARY** Relationship to patient \_\_\_\_\_  
Name of Insured \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_ Work Phone \_\_\_\_\_

**SECONDARY** Relationship to patient \_\_\_\_\_  
Name of Insured \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_ Work Phone \_\_\_\_\_

Does your plan require use of specific labs, hospitals or x-ray facilities? YES NO  
If yes, please list facilities to be used: \_\_\_\_\_

Do you have maternity coverage? YES NO

**IMPORTANT!!! Turn Over** 

# FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

## PAYMENT POLICY

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In order to avoid misunderstandings between the doctor and the patient we have the following policy in place. Co-pays and deductibles are due at the time of service. Patients with no insurance should expect to pay at the time of service. Please talk with a Financial Counselor if you need to set up payment arrangements for your visit. We will process insurance claims for office procedures or surgery, however, please be aware that you, the patient, are responsible for the bill. Accounts that are delinquent after 90 days may be subject to collection and all costs involved, including attorney fees, will be considered patient responsibility. Any legal action originating from a Bloomington Obstetrics & Gynecology, LLC account will be filed in the Monroe County Court system. I hereby authorize payment of medical benefits to Bloomington Obstetrics & Gynecology, LLC for services furnished to me by my provider. I further agree to pay all co-pays, deductibles, non-covered services or charges considered above usual and customary (non-contracted carriers only) by my insurance company.

\_\_\_\_\_  
(Initials)

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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I hereby give my consent for Bloomington Obstetrics & Gynecology, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Bloomington Obstetrics & Gynecology's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Bloomington Obstetrics & Gynecology reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Bloomington Obstetrics & Gynecology's Privacy Officer at 421 W. First St., Bloomington, IN 47403.

With this consent, Bloomington Obstetrics & Gynecology may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, Bloomington Obstetrics & Gynecology, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. With this consent, Bloomington Obstetrics & Gynecology, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Bloomington Obstetrics & Gynecology, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Bloomington Obstetrics & Gynecology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Bloomington Obstetrics & Gynecology, LLC may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

**Patients 18 years and under will need a parent or guardian signature authorizing treatment and consenting to financial responsibility.**