

PATIENT REGISTRATION
(PLEASE PRINT LEGIBLY)

DATE _____

NAME _____ SS# _____ DOB _____

ADDRESS: Street _____ City _____ Zip Code _____

HOME PHONE # _____ CELL PHONE # _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

REFERRING INFORMATION

PHYSICIAN NAME _____ PHONE # _____

GUARANTOR INFORMATION

NAME _____ SS# _____ DOB _____

ADDRESS: Street _____ City _____ Zip Code _____

HOME PHONE # _____ CELL PHONE # _____

RELATIONSHIP: SPOUSE MOTHER FATHER OTHER _____ (circle one)

EMPLOYMENT INFORMATION

EMPLOYER NAME _____ PHONE # _____

EMPLOYER ADDRESS _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME _____

POLICY # _____ GROUP # _____

INSURED NAME _____ INSURED DOB _____

RELATIONSHIP TO PATIENT _____ SS# OF INSURED _____

SECONDARY INSURANCE NAME _____

POLICY # _____ GROUP # _____

INSURED NAME _____ INSURED DOB _____

RELATIONSHIP TO PATIENT _____ SS# OF INSURED _____

I hereby authorize my insurance company(s) to pay directly to Beaufort OB/GYN Associates. I authorize release of information to any insurance company, hospital, or physician rendering treatment. I also authorize messages to be left on my answering machine.

PATIENT SIGNATURE

BEAUFORT OB-GYN ASSOCIATES, P.A.
989 Ribaut Road
Suite 210
Beaufort, South Carolina 29902
(843) 524-8151

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policy as an essential element of your care and treatment. If you have questions, please feel free to discuss them with our staff. *Unless other arrangements have been made in advance by yourself, payment is due at the time of service.* For your convenience, we accept Visa, Mastercard, Discover and American Express.

YOUR INSURANCE

Our office does not participate with all insurance plans. It is **your responsibility** to know if we are a participating provider with your insurance company. We will file a claim form on your behalf with those plans with which we have an agreement and will collect any co-payments/deductibles at the time of service. In the event your health plan determines a service to be *“not covered”* you are responsible for the complete charge. In that event, we will bill you and payment is due upon receipt of the statement.

If you have insurance coverage with a plan with which we do not participate, we will prepare and send the claim for you as a courtesy. Your insurance company will send payment for your services directly to you. **Charges for your care and treatment are due at the time of service unless other arrangements are made by you in advance.** We will also bill your health plan for all services we provide in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Please remember, your insurance policy is a contract between you and the insurance company and not our office. We will assist you in filing the claim, but you are ultimately responsible for all charges incurred.

Failure to adhere to our financial policy can result in dismissal from the practice and delinquent account information reported to the credit bureaus and collection agencies. **All cost incurred for collections will be charged directly to you.**

INSURANCE AUTHORIZATION

I hereby authorize Beaufort Ob-Gyn Associates, P.A. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by insurance. For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. I have read and understand the financial policy of the practice and I agree to be bound by its terms.

Signature of Patient or Responsible Party

Date

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize Beaufort OB/GYN Associates to release information regarding my health or finance history to the following:

Name	Phone #	Relationship
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Name	Phone #	Relationship
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Name	Phone #	Relationship
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Name	Phone #	Relationship
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Name	Phone #	Relationship
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Name	Phone #	Relationship
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Name	Phone #	Relationship
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Patient Signature

Date