This information is updated yearly for office purposes.

Patient's Legal Name: _____/_____/_____/_____
Last First Middle/Maiden Preferred Name

Address: _____
Street/ PO Box Apt/Unit/Lot# City State Zip Code

Date of Birth: _____/_____/_____ SSN: _____ Email: _____

Primary Phone: (_____)_____-_____ Alt Phone: (_____)_____-_____ Alt Phone: (_____)_____-_____
Cell Home Work Cell Home Work Cell Home Work

Text Notifications: Yes No Phone: (_____)_____-_____ Cell Carrier: _____

Marital Status: S M D W Race: _____ Primary Language: _____

Emergency Contact: _____ Phone: (_____)_____-_____ Relation: _____

Please complete this section if you are under the age of 18 with your parent's or legal guardian's information
Or if the subscriber of your insurance is someone other than yourself.

Name: _____
Last First Middle

Address: _____
Street/ PO Box Apt/Unit/Lot# City State Zip Code

Date of Birth: _____/_____/_____ SSN: _____ Relation: _____

Primary Phone: (_____)_____-_____ Alt Phone: (_____)_____-_____ Alt Phone: (_____)_____-_____
Cell Home Work Cell Home Work Cell Home Work

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Subscriber Name: _____ DOB: _____/_____/_____ Relation: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Subscriber Name: _____ DOB: _____/_____/_____ Relation: _____

Disclosure of Personal Health Information (PHI)

I, _____, give permission for Baldwin OB/GYN, P.C.'s physicians and staff to speak with specified person(s) regarding my medical condition, treatment, and or financial matters. Please list the individuals who may receive information either by telephone or in person upon providing proper identification.

Name: _____ **DOB:** ____/____/____ **Phone:** (_____)_____-_____**Relation:** _____
Can receive information pertaining to: Medical Financial Appointments All

Name: _____ **DOB:** ____/____/____ **Phone:** (_____)_____-_____**Relation:** _____
Can receive information pertaining to: Medical Financial Appointments All

Name: _____ **DOB:** ____/____/____ **Phone:** (_____)_____-_____**Relation:** _____
Can receive information pertaining to: Medical Financial Appointments All

_____ _____/_____/_____
Patient Signature required (if older than 14) **Date**

_____ _____/_____/_____
Legal Guardian Signature Date

Insurance Coverage Policy

Due to the many consistent changes in insurance policies, interpreting each individual's policy is a near impossible task. Therefore, we urge you, as the patient, to check with your insurance company before any exams or testing is performed. It is your responsibility to know the terms of your policy. Failure to do so may result in you being responsible for all cost incurred.

I acknowledge that I have read and understand Baldwin OB/GYN, P.C.'s insurance coverage policy.

_____ _____/_____/_____
Patient Signature **Date**

Agreement of Services Rendered

In consideration for the services to be performed, for the undersigned agrees to pay Baldwin OB/GYN, P.C. fees for services rendered at the time said services are rendered, and upon failure to pay for all sums due as set forth herein, I agree to pay reasonable attorney's fee and costs of collections if this matter is referred to an attorney. This authorization and agreement pertains to all services rendered by Baldwin OB/GYN, P.C. and its physicians and staff in connection with hospitalization rendered now or in the future. I further authorize Baldwin OB/GYN, P.C. to furnish information to insurance company carriers, and herby assign to the physicians of Baldwin OB/GYN, P.C. all payments for services rendered.

I acknowledge that I have read and understand Baldwin OB/GYN, P.C.'s agreement of services rendered.

_____ _____/_____/_____
Patient Signature **Date**

Baldwin OB/GYN, P.C. Financial Policy

We require the following before we can provide you care and treatment:

- Up to date and complete paperwork
- Copy of current insurance card(s) and ID
- Co-payment or payment for non-covered services

Missed or Cancelled Appointment Fees

- As a courtesy to our patients, your appointment will be confirmed by our automated confirmation system 2 business days prior to your appointment. This call will be placed after clinic hours for your convenience. Again, this is a courtesy reminder and there is no guarantee that the reminder system will be able to reach you.
- We require 24 hours' notice to cancel an appointment. Failure to do so will result in a **$25.00** "NO SHOW" fee for the majority of appointment types.
- We require a 48 hours' notice to cancel or reschedule any specialized testing appointments such as cardio vascular testing or urodynamics due to outside companies providing the technicians to perform these tests and the limited amount of days and times they are offered. Failure to do so will result in a **$50.00** "NO SHOW" fee.

Uninsured/ Self-Pay Patients

- All **new** self-pay patients are required to pay **$200.00** for their initial visit before services can be provided.
- All **established** self-pay patients are required to pay **$100.00** for any office visit before services can be provided.
- If an ultrasound is needed an additional **$100.00** will be required.

Payment at Time of Service

- If your insurance requires a co-payment you will be asked to pay for it, in full, before services will be rendered.
- A minimum payment on any outstanding balances will also be required before services will be rendered.
- Co-pays, co-insurance amounts, deductibles, and all non-covered charges are the patient's responsibility.
- Failure to make the required payments may results in your appointment being rescheduled.

Prescriptions

- All yearly prescriptions will be refilled upon attendance of your annual appointment unless otherwise arranged with the physician.
- Any phoned in, newly requested prescriptions, not previously prescribed by Baldwin OB/GYN, P.C., may result in a **$25.00** prescription fee in place of coming in for an appointment and paying your co-pay.

Surgery

- Before any non-emergency surgery is scheduled you will be given an *estimate* of the portion, if any, you will be responsible for based on the physicians' cost. You will have to contact the hospital about their charges.
- A minimum of half of your *estimated* cost will be required up front to schedule your surgery. A payment plan can be arranged for any remaining balance after surgery.

I acknowledge that I have read and understand Baldwin OB/GYN, P.C.'s financial policy.

_____ _____/_____/_____

Patient Signature **Date**

Please bring these forms completed to your appointment or you may fax them to 251-424-1110.

You must bring your insurance and ID cards with you to your appointment.