This information is updated yearly for office purposes.

Patient's Legal Name: ____________________/___________________/________________/_____________________
Last First Middle Initial Preferred Name

Mailing 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 Initial

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: ____

Subscriber Name: _________________________________ DOB: _______/_______/_______ Relation: ______________

Secondary Insurance: ____

Subscriber Name: _________________________________ DOB: _______/_______/_______ Relation: ______________

Disclosure of Personal Health Information (PHI)

I, ____________________________________, give permission for Baldwin GYN & Aesthetics, 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 (Patients 14 and older must sign per Alabama law) **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 GYN & Aesthetics, 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 GYN & Aesthetics, 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 pertain to all services rendered by Baldwin GYN & Aesthetics, P.C. and its physicians and staff in connection with hospitalization rendered now or in the future. I further authorize Baldwin GYN & Aesthetics, P.C. to furnish information to insurance company carriers, and herby assign to the physicians of Baldwin GYN & Aesthetics, P.C. all payments for services rendered.

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

____ _______/_______/_______
Patient Signature **Date**

Baldwin GYN & Aesthetics, 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

- We require 24 hours notice to cancel an appointment. Failure to do so will result in a **$25.00** “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 visits before services can be provided.

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 GYN & Aesthetics, 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 in order 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 GYN & Aesthetics, P.C.’s financial policy.

____ _______/_______/_______

Patient Signature **Date**

Name: ____ DOB: _____________________

Primary Care Physician: ____ Phone: _______________________

Medication List

Pharmacy: __________________________________

Prescription	Dosage	How/ When Taken

Allergies: ____

____

____

____

The nurse will get your family history and surgical information while she is working you up.