North Florida OB GYN LLC

Confidential Patient Information Form - Form must be filled out completely to ensure correct claim processing.

Social Security _____Patient _____
(Last) (First) (Middle Initial)

Date of Birth_____Address_____
(Street #) (City) (State) (Zip)

Home Tel#: _____Work Tel#: _____Patient Cell # _____

Employer_____ Patient E-Mail_____ Marital Status _____
(S M D W Sep)

Employment Status _____ (*FT PT Ret N/A)* **Student_____** *(FT PT)*

How did you hear about our office? _____

Referring Physician _____Primary Care Physician _____

Emergency Contact _____ Phone # _____

Spouse's name or other responsible party:_____ Phone # _____

Pharmacy Name, Phone #, Fax # and address_____

Primary Insurance: _____**Subscriber (Insured) Name** _____

Subscriber: Date of Birth_____ Social Security # _____Employer_____

ID#_____ Group Name & #_____ Patient Relationship to Insured_____
(Self, Spouse, Child)

Insurance Address_____
(City) (State) (Zip)

Second Insurance: _____ **Subscriber (Insured) Name_____**

Subscriber: Date of Birth_____ Social Security # _____Employer_____

ID#_____ Group Name & #_____ Patient Relationship to Insured_____
(Self, Spouse, Child)

Insurance Address_____
(City) (State) (Zip)

I understand that I am directly and primarily responsible to North Florida Obstetrical & Gynecological Associates, P.A., the parent company of North Florida OB GYN, LLC, for its customary fee for the services rendered to me by North Florida OB GYN, LLC. I realize that if my insurance company fails to pay or if there is any delay in paying North Florida Obstetrical & Gynecological Associates, P.A., it is my responsibility to pay my doctor's bill directly. I further understand and agree if I fail to make timely payments to North Florida Obstetrical & Gynecological Associates, P.A., that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s).

For the services rendered by North Florida OB GYN, LLC, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or the party who accepts assignment (North Florida Obstetrical & Gynecological Associates, P.A.). I authorize payment of medical benefits to the physician who submits the claim. I agree to hold North Florida OB GYN, LLC harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

I understand the office may employ an Advanced Registered Nurse Practitioner ("ARNP"), Midwife ("ARNP/CNM") or Physician Assistant ("PA"), and if I am scheduled with them, I am willing to see them instead of the doctor. I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I consent to electronic access to my medication history.

This form was last modified on 01/**01/2013**. I acknowledge that I have read this authorization and fully understand its contents.

Signature_____Date_____