We require 24 hours notice for cancellations; please call 812-945-5233 if you cannot keep this appointment.
Complete this form and bring it to your appointment.

# OB/GYN Associates of Southern Indiana

Doctor: Acct # «PNumber»

## Patient Information

Name: «PName»

Date of Birth:

Name you preferred to be called:

Address: «PStreet1»

City: «PCity» State: «PState»

Zip: «PZipCode»

Employer:

Home Phone: ( )«PHTele»

Occupation:

Work Phone: ( )«PWTele»

Patient Cell: ( )

E-Mail (If you'd like electronic statements):

Emergency Contact:

Emergency Contact Relationship:

Marital Status:

Emergency Contact Phone: ( )

Primary Care Physician ( PCP ) :

## Insurance Information

Payment is expected at the time of service. It is the patient's responsibility to know the limits of one's insurance policy. You must know if you need a referral, if you have a copay, or if you have any special requirements in your individual contract such as precertification for certain procedures. We will assist you in any way we can. However the patient is ultimately responsible for the bill. Thank You.

Primary Insurance:

Copay:

Subscriber Name:

Subscriber DOB: ____/____/_____ SS # _____

Insurance Carrier is: Patient Patient's Spouse Patient's Parent Other _____

Secondary Insurance:

Copay:

Subscriber Name:

Subscriber DOB: __/__/____ SS # _____

Insurance Carrier is: Patient Patient's Spouse Patient's Parent Other _____

**Authorization To Pay Benefits To Physician:** I hereby authorize my insurance benefits to be paid directly to OB/GYN Associates of Southern IN, P.S.C. I understand that I am financially responsible for any balance not covered by my insurance. By signing below, I also authorize OB/Gyn Associates of Southern Indiana to release any of my protected health information necessary for treatment, payment, and healthcare operations.

**Consent for Treatment:** I hereby consent to medical care at Ob/Gyn Associates of Southern Indiana. This care may involve diagnostic tests, procedures, prescriptions and medical exams.

Signature: _____ Date: _____

Parent/Guardian if patient is under 18: _____

Which of the following assisted you in choosing us as a provider? Check all that apply

___ Doctor Referral ___ Insurance ___ Phone Book ___ Obgynsi.com ____ Google or other search __ Friend or Family Person to thank _____