HUNTSVILLE OB/GYN ASSOCIATES, P.A.

ACCOUNT # ______________

____ ___/___/___ ________

LAST NAME **FIRST NAME** **M.I.** **DATE OF BIRTH** **AGE**

____

ADDRESS **CITY** **STATE** **ZIP CODE**

MARITAL STATUS (CIRCLE) S M W D **SSN** ________-________-________

RACE/ETHNICITY DESIGNATION :
___ **AMERICAN INDIAN OR ALASKA NATIVE** ___ **HISPANIC**
___ **ASIAN OR PACIFIC ISLANDER** ___ **BLACK** (NOT OF HISPANIC ORIGIN)
___ **WHITE** (NOT OF HISPANIC ORIGIN)

LANGUAGE ____ENGLISH OTHER ______________________________

HOME PHONE (______)______________________

CELL PHONE (______)______________________ **PHONE CARRIER**______________________________

EMPLOYER ______________________________________ **PHONE #** ______________________________

EMAIL ADDRESS ____

MAY WE TEXT APPOINTMENT REMINDERS TO YOUR MOBILE PHONE? ___**YES** ___**NO**

RESPONSIBLE PARTY ______________________________________ **RELATIONSHIP**______________

SPOUSE'S NAME ______________________________________ **DOB** _____/_____/_____

SPOUSE'S EMPLOYER ______________________________________ **PHONE #**______________________

EMERGENCY CONTACT (OTHER THAN SPOUSE)

NAME____ **PHONE #** ______________________

INSURANCE PAYMENT AUTHORIZATION: I I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS FOR SERVICES PROVIDED BY HUNTSVILLE OB/GYN ASSOCIATES, P.A., TO BE PAID DIRECTLY TO HUNTSVILLE OB/GYN ASSOCIATES, P.A. I UNDERSTAND THAT PROCEDURES DONE BY HUNTSVILLE OB/GYN ASSOCIATES P.A. AND APPROVED BY ME MAY NOT BE COVERED BY MY INDIVIDUAL INSURANCE CONTRACT. I ACCEPT RESPONSIBILITY FOR FULL PAYMENT OF THESE CHARGES.

PAYMENT TERMS: AS CONSIDERATION FOR HUNTSVILLE OB/GYN ASSOCIATES, P.A.'S SERVICES, I AGREE TO PAY ALL CHARGES FOR SERVICES AT THE COMPLETION OF SUCH SERVICES, OR TO MAKE PAYMENT ARRANGEMENTS WITH THE BOOKKEEPING OFFICE PRIOR TO THE SERVICES BEING PERFORMED. ANY UNPAID BALANCE MAY BE PLACED WITH A COLLECTION AGENCY IF DEFAULT OCCURS. IF PLACED WITH A COLLECTION AGENCY, I AGREE TO PAY ANY REASONABLE COSTS ASSOCIATED WITH COLLECTION INCLUDING ATTORNEY'S FEES, COURT COSTS, ETC.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS

X ____ **DATE** _____/_____/_____

SIGNATURE OF PATIENT
(Parent may sign for any child under the age of 14)