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)