Bobbie Behrens
M.D.,OB/GYN, LLC

Patient Name: **Date of Birth:**
Previous Name(s): _____
Parent/Guardian (if under 18): _____ **Parent/Guardian Date of Birth** _____
Mailing Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Physical Address: _____ **State:** _____ **Zip Code:** _____
Primary Phone: **«HomePhone»** **OK to leave a message?** □ Brief □ Extended □ No
Secondary Phone: _____ **OK to leave a message?** □ Brief □ Extended □ No
Gender: □ Male □ Female **Social Security Number:** _____
Marital Status: □ Single □ Married □ Divorced □ Separated □ Partner □ Separated
Email Address: _____
Emergency Contact Name: _____ **Relationship:** _____
Phone Number: _____

How would you like us to remind you of your appointment and normal labs? Please only check ONE:
□ Automated call to your **Primary** phone □ Automated call to your **Secondary** phone □ Text to your **Primary** phone □ Text to your **Secondary** phone

Race: □ Asian
□ American Indian / Alaskan Native
□ Native Hawaiian or Other Pacific Islander
□ Black or African American
□ White
□ Hispanic
□ Other Race
□ Decline

Ethnicity: □ Hispanic or Latino
□ Not Hispanic or Latino
□ Decline

Language: □ English
□ Spanish
□ Russian
□ Other:

Preferred Pharmacy: _____

Primary Insurance Information

SELF PAY □
Person Responsible for bill: _____
Primary Insurance: _____
Subscriber ID: _____ **Group Number:** _____
Subscriber Name/relationship _____ _____**Subscriber Date of Birth**: _____
Do you have Medicaid? □ Yes □ No **If Yes, ID Number:** _____ _____

Secondary Insurance Information

Secondary Insurance: _____
Subscriber ID: _____ **Group Number:** _____
Subscriber Name/relationship _____ **Subscriber Date of Birth:** _____

Employer Information

Employer Name: _____

Work Number: _____ **Address:** _____

OK to leave a message? □ Brief □ Extended □ No

I verify that the above information is correct.

Signature: _____ Date: _____

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD

The doctor may order laboratory tests as part of your treatment. You will be billed directly from the laboratory for these services. Payment of these tests are payable by you.

REGARDING INSURANCE

We do ask for a copy of your insurance cards for your file. In the event that your require surgery, we will bill out for those charges. We will also bill out for obstetric care and deliveries. We do bill secondary insurances that we are contractual with. Your insurance policy is a contract between you your and your insurance company. We are not a party to that contract.

If your insurance company has not paid your account in full within 45 days, you will need to make arrangements for paying the balance. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable and necessary under Medicare/Medicaid and/or other medical insurance companies. There will be a monthly finance charge applied to your account for balances left unpaid, after 30 days, at the rate of 10.5% annually.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what we consider to be usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient/Guardian Signature _____ ***Date*** _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Dr. Bobbie Behrens, M.D.

I acknowledge that I have received a copy of Dr. Behrens, Notice of Privacy Practices with the effective date of April 12, 2003.

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

DOCUMENTATION OF GOOD FAITH EFFORTS

To obtain patient's acknowledgment that they received Dr. Behrens Notice of Privacy Practice

Patient Name: __«FirstName» «LastName» «MiddleInitial»_____Date: _____

The Patient presented to the office and was provided with a copy of our Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written Acknowledgment of his/her receipt of the Notice.
However, such acknowledgment was not obtained because:

- □ Patient refused to sign
- □ Patient was unable to sign or initial because: _____
- □ Patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- □ Other reason (describe): _____

Signature of Employee Completing form: _____
Printed Name of Employee: _____