



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: _____ 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: _____ Primary Care Provider: _____

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

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

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 you 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 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 or 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: _____