University Park Obstetrics and Gynecology, LLC -Shawn Stephens, M.D.

(Please Print)			Today's Date: / /
Patient's last name:		**First:**	**Middle:**
Birth date: / /	**Age:**	**Marital status (circle one)**	**Single / Mar / Div / Sep / Wid**
Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**		
Street address:		**P. O. Box:**	**Email Address:**
City:	**State:**	**ZIP Code:**	**SS#:**
Cell Phone:	**Home Phone:**	**Work Phone:**	
Occupation:	**Employer:**		
How did you hear about our office?	**❑ Dr.**	**❑ Insurance Plan**	**❑ Hospital**
❑ Family	**❑ Friend**	**❑ Close to home/work**	**❑ Yellow Pages**	**❑ Other**	**Describe:**

Race: ❑ African American/Black ❑ Asian ❑ Caucasian/White ❑ Pacific Islander/Native Hawaiian ❑ Hispanic/Latino ❑ American Indian/Alaskan Native ❑ Other

Ethnicity: ❑ Hispanic/Latino ❑ Non Hispanic or Latino **Preferred Language** ❑ English ❑ Spanish ❑ Other_____

Preferred Pharmacy: **Location:** **Phone:**

INSURANCE INFORMATION

(Please give your insurance card and photo identification to the receptionist.)

Please indicate primary insurance:					
Insurance ID#:	**Group #:**	**Co-pay: $**			
Subscriber's name:	**Subscriber's Birth date: / /**				
Subscriber's S.S. #:	**Patient's relationship to subscriber:**	**❑ Self**	**❑ Spouse**	**❑ Child**	**❑ Other**
Name of secondary insurance:	**Subscriber's name:**				
Group #:	**Policy #:**				

IN CASE OF EMERGENCY

Name of local friend or relative to contact:		
Home phone #:	**Work phone #:**	**Relationship to patient:**

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

May we call you on your cell?	**Yes**	**No**	**May we send a yearly recall to your home?**	**Yes**	**No**
May we leave a message on your cell ?	**Yes**	**No**	**May we call you at work?**	**Yes**	**No**

I authorize University OBGYN to speak with _____ regarding my healthcare/PHI .
(relationship to you) _____ Phone Number #_____

I acknowledge and agree to adhere to the Notice of Privacy Practices as required by federal and state guidelines. I have been provided a copy of the Notice of Privacy Practice and understand that I may request and review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims.

Patient/Guardian signature	***Date***

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I have completed this form and certify that I am the patient or duly authorized agent of the patient. I authorize the providers of University Obstetrics and Gynecology, LLC to provide medical care and treatment for me. I understand Medical Treatment may include a Medically indicated examination including but not limited to a Pelvic Exam. I authorize University Obstetrics and Gynecology, LLC to obtain verification of my medication/prescription history in order to provide continuity of care. I authorize release of my medical information as directed by my physician for outside referrals to specialists, hospitals, laboratories and others as necessary for my continued care.

I hereby authorize payment of benefits to be made directly to University Obstetrics and Gynecology, LLC and/or any of the providers individually. I understand, as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service or statement and billing fees may be assessed. I understand that any overpayment I make will be refunded if the credit amount is over $20.00, otherwise, the credit will be held for 18 months for future balances unless a request for refund is received.

Patient/Guardian signature	***Date***