

PLEASE PRINT
PATIENT REGISTRATION FORM

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Patient Date of Birth: _____ Social Security #: _____

Any Previous Last Names: _____

Employer: _____

Email Address: _____ (required for Portal Access)

Patient Cell Phone Number: ()- -

Patient Home Phone Number: ()- -

Marital Status: Single Married Divorced Widowed

Preferred Pharmacy: _____

Patient Family Doctor: _____

Which method of contact would you prefer for appointment reminders?

We suggest choosing only one, but you may select multiple if desired.

____ E-mail

____ Text Message

____ Phone Call to Cell Phone

____ Phone Call to Home Phone

Note: If none of the above are selected, the contact method will default to a Phone call to your Home Phone if available.

Please check the identification group(s) that best applies to you. Check all that apply (optional):

Race

<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian	<input type="checkbox"/> Other
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		

Ethnicity

<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino
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Privacy Statement:

Your privacy is our utmost concern. In accordance with HIPAA regulation, we will keep your contact information private. This contact information will only be used by us to contact you for purposes pertaining to your medical care, such as appointment reminders, office announcements, and lab results.

1. RECEIPT OF NOTICE OF PRIVACY PRACTICES, WRITTEN ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have received a copy of OB/GYN Associates of Erie's Notice of Privacy Practices.

PRINT NAME OF PATIENT

DATE OF BIRTH

DATE

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

PERSONAL REPRESENTATIVE'S NAME

RELATIONSHIP TO PATIENT

2. AUTHORIZATION TO RELEASE INFORMATION TO ANOTHER INDIVIDUAL (OPTIONAL)

I authorize OB/GYN Associates of Erie to release information regarding my care and treatment to:

PRINT NAME

RELATIONSHIP

PHONE NUMBER

DATE

This consent is valid unless revoked by me in writing before the release of the designated information.

3. IN HOUSE TESTING

OB/GYN Associates of Erie performs in house testing including lab, sonograms, mammograms, and bone densities. The interpretations of our mammograms are billed through OB/GYN Associates of Erie and UPMC Hamot. Our PAP smears, biopsies, and specialty labs are sent to Associated Clinical Laboratories (ACL) or LabCorp and they do the billing. If you would prefer to have your test done at another facility, please notify your provider.

4. INSURANCE AUTHORIZATION - PLEASE PRESENT CARD FOR SCANNING

I request that payment of authorized Medicare benefits be made either to me or on my behalf to OB/GYN Associates of Erie for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize the release of any medical information necessary to process insurance claims and request payment of insurance benefits to be made directly to OB/GYN ASSOCIATES OF ERIE. I understand that I am financially responsible for all charges whether or not paid by said insurance.

5. TELEPHONE CONSUMER PROTECTION ACT (TCPA)

You agree, in order for us to service your account or to collect monies you may owe, OB/GYN Associates of Erie, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that OB/GYN Associates of Erie, PC, its employees and/or agents may contact me/us as described above.

SIGNATURE OF PATIENT/PERSONAL REPRESENTATIVE

DATE

OB-GYN Associates of Erie - Practice Financial Policy

This financial policy has been established to clearly communicate patient responsibilities regarding payment, insurance, and billing for care received at our OB-GYN practice. Please review carefully and ask any questions before signing.

1. Insurance and Coverage Verification

- We accept most major insurance plans; however, **it is the patient's responsibility** to ensure our office is in-network with their specific plan.
 - Patients must provide **accurate and up-to-date insurance information** before the appointment.
 - If insurance cannot be verified, the visit may be billed as **self-pay**.
 - Coverage for services such as **ultrasounds, labs, genetic testing, and in-office procedures** varies by plan. Patients are responsible for all non-covered services.
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2. Copayments, Deductibles, and Coinsurance

- **Copayments are due at the time of service.**
 - Any unmet **deductible or coinsurance** amounts determined by your insurer are the patient's financial responsibility.
 - For obstetrical care, a **global maternity billing estimate** may be provided, but the final balance may differ based on insurance processing and services performed outside the global package.
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3. Maternity Care Billing

- Routine prenatal care is billed as a **global maternity package**, typically including:
 - Routine prenatal/Postpartum visits
 - Delivery
 - The global package **does NOT include**:
 - Labs
 - Ultrasounds
 - Non-stress tests
 - Genetic testing
 - Hospital or specialist fees
 - Management of high-risk conditions; Maternal Fetal Medicine
 - Patients will receive separate bills from labs, hospitals, anesthesia services, and any outside specialists.
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4. Annual Well Woman Gynecological Exams (Preventive Visits)

Annual well-woman examinations are billed as **preventive services** and are intended for routine screening only. These visits do not include evaluation or management of new or existing medical problems.

If, during the Well Woman Exam, you discuss **symptoms, concerns, or conditions** that require additional evaluation or treatment, the provider is required by insurance rules to bill a problem-oriented office visit **in addition** to the preventive service.

As a result, you may incur the following based on your insurance plan:

- A **co-payment**,
- **Deductible** charges
- **Coinsurance**

6. Self-Pay / Uninsured Patients

Self-pay patients must pay **in full at the time of service**, unless a payment plan is established in advance.

- A **Good Faith Estimate (GFE)** will be provided in accordance with the No Surprises Act.
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8. Billing Statements and Payment Terms

- Statements are issued monthly for outstanding balances.
 - Balances are due within **30 days** unless a payment plan is approved.
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9. Payment Methods

We accept:

- Cash
 - Debit/credit cards
 - HSA/FSA cards
 - Approved payment plans
 - Online bill pay
 - Returned checks are subject to a **\$25** fee.
-

10. Payment Plans

- Must be arranged **before** the account becomes delinquent.
 - Missed payments may cancel the agreement and send the balance to collections.
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11. Workers' Compensation, Auto Accidents, and Legal Cases

- We do **not** bill third-party liability or auto insurance without prior agreement.
 - Patients may be required to pay upfront and seek reimbursement from the third party.
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12. Medical Records and Forms

- Standard medical records requests are of no cost to the patient. Variable fees will apply to requests coming from a third-party entity.
 - Completion of forms (FMLA, disability, etc.): **\$35** per form.
 - Payment is due at the time of request.
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13. Refund Policy

- Refunds for overpayments are processed after:
 1. Insurance reconciliation, and
 2. Confirmation that no additional balances exist.
 - Refunds are issued within **30–45 days** after payment is processed.
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Patient Acknowledgment

I understand and agree to comply with the financial policies outlined above. I accept responsibility for all charges not covered by my insurance.

Patient Printed Name: _____ **Date:** _____

Patient Signature: _____