COLUMBUS OBGYN SPECIALTY CENTER, PLLC
PATIENT INFORMATION SHEET

Chart #:
Office Use

TODAY'S DATE: ______________

PATIENT'S LEGAL NAME: ____
(First) (MI) (Maiden) (Last)

Social Security #: ________-________-________ **Birthdate:** ______/______/______ **Age:**__________

Marital Status: Single Married Separated Divorced Widowed

Complete Address: ____

City: ______________________ **State:** ______________ **ZIP:**________-________

Private Email: ____

Home Phone:(______) ______-________ **Cell Phone:(______)** ______-________

Employed By: ______________________ **Occupation:**______________________

Work Phone: (______) ______-________ **May we call you at work? Yes No**

SPOUSE'S NAME: ______________________________ **Birthdate:** ______/______/______
(First) (MI) (Last)

Spouse's Social Security #: ________-________-________ **Contact Phone:(______)** ______-________

Employed By: ______________________ **Occupation:**______________________

IF MINOR, NAME OF PERSON RESPONSIBLE FOR PAYMENT: ______________________

Relationship to minor ______________________ **Contact Phone:(______)** ______-________

Social Security #: ________-________-________ **Birthdate:** ______/______/______

Complete Address: ____

City: ______________________ **State:** ______________ **ZIP:**________-________

INSURANCE INFORMATION: We must have ALL of the information below AND a copy of the insurance card.

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Company:	**Name of Company:**
Name of Insured:	**Name of Insured:**
Insured's Date of Birth:	**Insured's Date of Birth:**
Relationship to Insured:	**Relationship to Insured:**

Due to constant changes and varieties of insurance plans, you will need to present your insurance card to the receptionist each time you visit our office. If you do not have your card, please expect to pay the full amount for that visit. When insurance information is received, we will file for you. Also, we do not accept assignment on all insurances, so please check with the business office prior to seeing the provider if you have any questions about your financial responsibility. All patient financial portions are due at the time services are rendered.

How did you hear about our office? Doctor/Friend Referral______________________
Website Telephone Directory Billboard Commercial Other ______________

COLUMBUS OBGYN SPECIALTY CENTER, PLLC

Insurance Information

Patient Name: ______________________________________ **Date of Birth:** ____________

Previous and/or Maiden Name(s): ______________________________________

Address: ____

City, State, Zip: ____

Primary Phone #: ___________________ **Secondary Phone #:**_____________________

Social Security # or Driver License #: ____

Primary Insurance:

Insurance Company Name: ____

Claims Address: ____

City, State, Zip: ____

Insured's Name: ____

Policy #: _________________________ **Group/Plan #:** ____________________________

Secondary Insurance:

Insurance Company Name: ____

Claims Address: ____

City, State, Zip: ____

Insured's Name: ____

Policy #: _________________________ **Group/Plan #:** ____________________________

***If anything is sent to pathology (i.e. pap smear, biopsy, etc.), a copy of this form will go to the lab so that they can file your insurance. You will receive a separate bill from that facility for any balance that your insurance does not pay.**

COLUMBUS OBGYN SPECIALTY CENTER, PLLC

Payment Policy

It is the policy of Columbus ObGyn Specialty Center that payment is due at the time services are provided. It is the patient's responsibility to check with the business office prior to being seen if you have any questions regarding fees, insurance information, etc. All outstanding balances must be paid in their entirety before any additional services will be provided by any provider employed at Columbus ObGyn Specialty Center.

Self-Pay — **All self-pay patients are responsible for payment of their entire account at the time services are provided. For scheduled surgeries performed in the hospital, payment is due when the patient gets her preoperative orders. If a non-scheduled surgery is performed, payment is due immediately following discharge. If the entire balance cannot be paid at once, arrangements must be made with the business office immediately.**

***Medicare** — **The providers of this clinic are NONparticipating providers with Medicare. Therefore, Medicare beneficiaries are responsible for payment of all services received in the office the day the service is provided. We will collect the limiting charge that is set by Medicare, and you will only be reimbursed 80% of that amount after your deductible has been met. Medicare will send this payment directly to you. Medicare will then cross your claim over to your supplemental carrier, and if a payment is due, it will be made directly to you also.**

Medicaid — **The providers of this clinic do participate with Mississippi Medicaid and UnitedHealthCare Community Plan of the MississippiCAN Program. If a patient has Medicaid, they must present their card before services are provided. All applicable copays are due at the time services are rendered. If the Medicaid is not in effect at the time of service, you are responsible for payment. If Medicaid becomes effective and you qualify for "retroactive eligibility", our office WILL NOT bill Medicaid for those services and REFUND the beneficiary.**

Private Insurance — **The providers of this clinic do not participate with all private insurances, and it is the patient's responsibility to check with the business office prior to being seen if you have any questions regarding your coverage here. For those insurances that we do not accept, the patient is responsible for payment in full at the time of the service, and we will give you a form that you can file with your insurance carrier to receive your benefits. For those insurances that we do accept, the patient is responsible for payment as outlined by their plan. Therefore, office copays, deductibles, and coinsurance amounts are due at the time of service. After the insurance has paid, the patient is responsible for any remaining balance. If payment arrangements need to be made, you must contact our business office immediately.**

We are participating providers for the following networks:
BCBS of Mississippi, BCBS of Alabama, State Employees Network,
MPCN (Mississippi Physicians Care Network), Baptist Network,
UnitedHealthCare, Cigna, and Tricare (Standard and Prime).

If you have any questions about your insurance, ask someone in our business office prior to being seen by the provider. We will gladly assist you in finding out what your benefits are for the services provided in our clinic. It is the patient's responsibility, not the employees of Columbus ObGyn Specialty Center, to know your benefits, and ultimately it is the patient's responsibility for payment of their accounts.

I have read the above payment policy and understand my financial responsibility as a patient. I know that I can ask someone in the business office about my financial obligations prior to services being provided if I have any questions.

____ ____________________

Patient's Signature or Parent/Guardian (if a minor) **Date**

COLUMBUS OBGYN SPECIALTY CENTER, PLLC

Patient Name: ____ **Chart#:** ____________

First **Middle Initial** **Last**

Patient's Date of Birth: ______________ **Patient's Social Security # or Driver License #**______________________________

HIPPA Privacy Notice Acknowledgement

I have read the Notice of Privacy Practices for Columbus ObGyn Specialty Center. I understand that I may ask questions if I do not understand any part of the notice. I may also request a copy of the notice for my personal records.

____ ____________________

Signature of Patient **Date**

Authorization for Disclosure of Private Health Information to Family/Friend

I hereby authorize Gregory W. Childrey, M.D., Clay B. Hudson, M.D., and their staff to discuss my private health information, to include the results of my medical tests such as pap smears, biopsies, exam findings, etc., and the need for further treatment based on the findings of such tests, with the following person(s):

Name	Relationship
______________________________	____________________
______________________________	____________________
______________________________	____________________

I understand that because the person(s) receiving this information is/are not a health plan(s) or health care provider(s) covered by federal privacy regulations, the information may be disclosed by the recipient(s) and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Columbus ObGyn Specialty Center in writing and that if I choose to do so, my request to revoke will not affect any actions by Columbus ObGyn Specialty Center before receiving my revocation.

____ ____________________

Signature of Patient **Date**

Authorization Denied to Disclose Private Health Information to Family/Friend

I am not a minor, and I do NOT want my private health information to be disclosed to any family member or friend. I understand that my refusal will not affect my treatment, payment, or eligibility for benefits.

____ ____________________

Signature of Patient **Date**

COLUMBUS OBGYN SPECIALTY CENTER, PLLC

Patient Name: ____ Chart#:________________

(First) (Maiden or Middle Initial) (Last)

ASSIGNMENT OF BENEFITS AUTHORIZATION

I hereby authorize Columbus ObGyn Specialty Center to furnish information to insurance carriers concerning my illness and treatments, including office/progress notes, surgical reports, laboratory and pathology results, and any other information necessary to process claims filed. I hereby assign to the provider(s) all payments for medical/surgical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance if assignment was taken.

____ __________________

Signature of Patient or Guardian/Parent (if a minor) Date

NONDISCRIMINATION POLICY

Columbus ObGyn Specialty Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services, and activities, or in employment.

COMMUNICATION WITH PERSONS OF LIMITED ENGLISH PROFICIENCY (LEP) AND FOR PERSONS WITH IMPAIRED HEARING, VISION, OR SPEECH

Columbus ObGyn Specialty Center will provide communication aids (at no cost to the person being served) to Limited English Proficient (LEP) persons and to persons with impaired hearing, vision, or speech, who wish to be patients here at our practice. If any of these resources are needed, please notify our office <u>PRIOR</u> to the day of your appointment so that arrangements can be made. Our contact number is 662-240-0095.

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Signature of Patient or Guardian/Parent (if a minor) Date