Galvan OBGYN Patient Registration Form

Patient Information

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	MOBILE PHONE	DATE OF BIRTH	SOCIAL SECURITY NO.
EMPLOYER		OCCUPATION	MARITAL STATUS
WORK PHONE	May we call you at work? ☐ Yes ☐ No	E-MAIL ADDRESS	
SPOUSE / SIGNIFICANT OTHER			
EMERGENCY CONTACT			PHONE NUMBER

Responsible Party (if someone other than the patient is responsible for payment).

NAME		RESPONSIBLE PARTY DATE OF BIRTH	RESPONSIBILITY PARTY SOCIAL SECURITY NO.
HOME PHONE	MOBILE PHONE	EMPLOYER	
NAME		RELATIONSHIP	
HOME PHONE	MOBILE PHONE	MAILING ADDRESS	

Medical Insurance Information

PRIMARY INSURANCE COMPANY	ADDRESS	CITY, STATE, ZIP	PHONE
ID/SUBSCRIBER NO.	GROUP POLICY NO.	**CHOOSE ONE** ☐ Your Employer ☐ Spouse ☐ Other	
SECONDARY INSURANCE COMPANY	ADDRESS	CITY, STATE, ZIP	PHONE
ID/SUBSCRIBER NO.	GROUP POLICY NO.	**CHOOSE ONE** ☐ Your Employer ☐ Spouse ☐ Other	

Do you give Dr. Galvan and staff permission to leave a message for you at work? (circle one) Yes No

On your cell? (circle one) Yes No At home? (circle one) Yes No

Do you give Dr. Galvan and staff permission to discuss your health care issues with a spouse, significant other, or designated person? (circle one) Yes No

If yes, please list these individuals below and their phone numbers:

NAME 1	PHONE NUMBER
NAME 2	PHONE NUMBER
NAME 3	PHONE NUMBER

Signature of Patient ______________________________ Date ____________

Signature of Responsible Party ______________________________ Date ____________

Consent for Treatment: I authorize and consent to the performance of medical or surgical treatment and/or laboratory testing considered necessary or advisable by the physician and staff at Galvan OB/GYN and Associates.

Financial Agreement: I hereby authorize direct payment of medical and surgical benefits to Galvan OB/GYN and Associates. I understand that I am financially responsible for any balance not covered by insurance. In the event that my account becomes past due, I understand that my account may be turned over to a collection agency. If my account is not paid in full and is turned over to a collection agency and/or attorney, I agree to be responsible for all responsible fees necessary for the collection of the delinquent account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney's fees of 33% of the balance. I understand that it is my responsibility to verify insurance coverage with my insurance company and to call my insurance company for authorization prior to hospitalization or procedures.

Consent for use of Protected Health Information (PHI) for treatment, payment and Healthcare operations: My (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This "PHI" relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use of disclosure of my 'PHI' for the purpose of diagnosis or treatment of me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my 'PHI' is used or disclosed to carry out treatment, payment or healthcare operations of the practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that my provider has taken action in reliance on this consent.

I understand I have a right to review my provider's Notice of Privacy Practices at any time and prior to signing this consent.

X ____

Signature of Patient (or Guardian) **Date**