Galvan OBGYN Patient Registration Form

Patient: _____
Last Name First Name Middle 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? Email Address

_____
Spouse/Signifcant Other

_____
Emergency Contact Phone Number

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

Name: _____ Date of Birth: _____

_____
Home Phone Mobile Phone Employer

Name: _____ Relationship: _____

_____
Home Phone Mobile Phone Mailing Address

Medical Insurance Informaiton

_____
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? Yes No (circle one)
On your cell? Yes No (circle one) At home? Yes No (circle one)
Do you give Dr. Galvan and staff permission to discuss your health care issues with a spouse, significant other, or designated person? Yes No (circle one)
If yes, please list these individuals below and their phone numbers

_____
Name 1 Name 2 Name 3

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.

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 on this document.

I understand I have the right to request a 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**