Galvan OB/GYN & Associates

1300 Franklin Ave, Suite 330
Normal Il 61761
Ph 309.454.7400
Fax 309.454.7471

Date Completed _____

PATIENT INFORMATION Preferred Pharmacy _____ Location _____

Name _____
Last Name First Name M.I. Preferred Name Maiden Name

Address _____
Street City and State Zip Code

Home Phone_____ Cell Phone_____ Work Phone_____ * circle your preferred number

May we leave a message at your preferred number? __Yes __No May we text you reminders? __Yes __No

Email_____ *By providing your email you are agreeing to receive an invite to our patient portal.

Birth date_____ Age____ Marital Status __S__M__W__D SS#_____-_____-_____

Race __American Indian/ Alaskan Native __Asian __Black/African American __Natural Hawaiian/ Pacific Islander

__White __Other __Unknown __Decline

Ethnicity __Hispanic or Latino __Not Hispanic or Latino __Unknown __Decline

Employed by _____ Occupation_____

Spouse's Name _____ Spouse's Employer _____

Emergency Contact _____ Phone Number_____ Relation_____

How did you hear about us?_____ Doctor Referral:_____

IF PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION

Guarantor Name _____
Last Name First Name M.I.

Address _____
Street City and State Zip Code

Guarantor Birth date_____ Home Phone_____ Work Phone_____

Relationship to patient_____

PRIMARY INSURANCE COVERAGE

Name of policy holder_____

Insurance Company_____

Policy holder's date of birth_____

Policy holder's SS#_____

SECONDARY INSURANCE COVERAGE

Name of policy holder_____

Insurance Company_____

Policy holder's date of birth_____

Policy holder's SS#_____

CONSENT TO TREAT

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physician's choice. Our office follows the standards of care recommended by the American College of Obstetricians and Gynecologists (ACOG) and the Center for Disease Control (CDC).

HIPPA AUTHORIZATION Initials

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physician's choice.

For further explanation or for a copy of our HIPPA Privacy Notice please see the front desk staff or visit our website. This release to effective until revoked by the patient with written signature.

Please mark the appropriate section below:

_____No restrictions ____ Restrictions: (please list your restrictions)

_____

_____

If there is anyone you would allow us to share information with, please list the names and relationships of those people below.

_____May share my protected health and financial information with:

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Initials

FINANCIAL AGREEMENT

- It is your responsibility to inform our office of any address, telephone number or insurance changes.
- Your account is to be kept current– accordingly, all self-pay or insurance co-payments, co-insurances, and deductibles will be collected at the time of service. Payable by cash, check, Visa, or MasterCard.
- If you do not have your payment(s), your appointments may be rescheduled.
- You may be asked to be schedule another appointment for issues other than the reason for your original appointment.
- A returned check will result in a $25 service charge and all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $5.
- Refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims.
- Any unpaid balances older than 30 days may be subject to 2% interest per month.
- If your account is assigned to a collection agency, you will be responsible for any costs incurred in collection of said balance, which will include collection agency fees of 30%, court costs and attorney fees and will not be able to schedule further
- appointments.
- **Missed appointments (no-show) may result in a fee that will be charged to you. Not your insurance company.** Initials

We will submit your insurance claims. ***However, we must emphasize that as medical providers, our relationship is with you not your insurance company.*** We attempt to verify your benefits. Please be advised this is only an estimate of your coverage based on the information give to us at the time of the inquiry.

- Not all services are a covered benefit will all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filling your insurance claims is a courtesy extended to you, all charges are always your responsibility.
- We realize that temporary financial problems may affect timely payment. We urge you to contact us promptly for assistance.

Initials

I authorize Galvan OB/GYN & Associates to release to my insurance carrier and its agents any information needed to determine the benefits payable under their coverage. I authorize my insurance company and its carriers to disclose any information requested
regarding claims for medical benefits. A copy of this authorization may be used in place of the original request that payment of authorized medical benefits be made on my behalf to Galvan OB/GYN & Associates for services furnished to me.

Your signature below indicates that you understand and agree to the above

Signature of Patient:_____ Date:_____

Signature of Parent/ Legal Guardian:_____ Date:_____

We look forward to providing you with the highest quality care and trust. We hope you find us friendly and helpful. You may receive a patient satisfaction survey and we would appreciate it, if you could take a few minutes to let us know how we are doing.