



CELEBRATION OBSTETRICS AND GYNECOLOGY

A MEDICAL PRACTICE DEDICATED TO WOMEN'S HEALTH
410 Celebration Place, Suite 208, Celebration, FL 34747
2209 North Boulevard West, Suite C, Davenport, FL 33837
phone: 407-566-2229 fax: 407-566-2499

PATIENT INFORMATION:

FIRST NAME: _____ LAST NAME: _____ MIDDLE INITIAL: _____

STREET ADDRESS: _____ APT#: _____

CITY: _____ STATE: _____ ZIP: _____

AGE: _____ BIRTH DATE: ____ - ____ - ____ MARTIAL STATUS: SINGLE MARRIED OTHER
please circle one

SOC. SEC. : ____ - ____ - ____ HOME PHONE: _____

EMAIL ADDRESS: _____

CELLULAR PHONE: _____ PATIENT'S OCCUPATION: _____

EMPLOYED BY: _____ PHONE: _____ EXT: _____

BUSINESS ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SPOUSE'S FIRST NAME: _____ LAST NAME: _____ BIRTH DATE: ____ - ____ - ____

SPOUSE'S OCCUPATION: _____ EMPLOYED BY: _____

IN CASE OF EMERGENCY? _____ RELATIONSHIP: _____ PHONE : _____

Who May We Thank for Referring you to the Practice? _____

PRIMARY INSURANCE INFORMATION:

NAME OF PERSON RESPONSIBLE FOR INSURANCE: _____

RELATIONSHIP TO PATIENT: _____ BIRTH DATE: ____ - ____ - ____ SOC. SEC.: ____ - ____ - ____

INSURANCE COMPANY NAME: _____ CARD ID #: _____

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, (OR MY DEPENDENT) HAS INSURANCE COVERAGE WITH _____
NAME OF INSURANCE COMPANY

AND ASSIGN DIRECTLY TO CELEBRATION OBSTETRICS AND GYNECOLOGY ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. IN CASE AN ACTION IS INSTITUTED TO COLLECT THIS NOTE OR ANY PORTION THEREOF, THE BELOW NAMED PATIENT PROMISES TO PAY ALL COLLECTION COSTS AND ADDITIONAL SUMS AS MAY BE DEEMED RESPONSIBLE IN SAID ACTION, I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

PATIENT OR GUARANTOR SIGNATURE

RELATIONSHIP

DATE



BILLING AND FINANCIAL POLICY

Please initial in the space provided and sign your name acknowledging your consent and agreement.

If you have insurance, we will provide insurance claim filing for your primary insurance plan with which we participate; however, if we do not accept your insurance plan or if a **claim is denied or a balance is due, you are responsible for payment of the balanced owed and we expect payment within 30 days from the date we notify you of such determination. It is our policy that we do not take secondary insurance and do not file claims to secondary insurance. It is your responsibility to pay any co-pay, deductible, co-insurance or any other balance not paid for by the insurance or third party payer within 30 days. Please note all claims must be finalized before any refunds will be submitted for processing. Refund processing can take up to 30 days to issue. For Obstetrical patients all claims including delivery must be finalized.**

It is the responsibility of the patient/guardian to provide us with current insurance plan information prior to services rendered in order for accurate billing of services to be filed. You are also responsible for contacting your insurance company to make sure we are in network with your particular plan. It is important that you are familiar with the guidelines of your plan requirements regarding authorizations, deductibles, co-payments and other vital requirements.

It is the responsibility of the patient/guardian to obtain any referrals that may be required by the insurance company PRIOR to the scheduled visit. Failure to do so will result in the need to reschedule your appointment and a potential \$25.00 late notice rescheduling fee may apply.

In consideration of services rendered, you agree to transfer and assign to Celebration Obstetrics and Gynecology all rights, title and interest in any payment due to you or otherwise payable to you for services rendered.

Insurance: (initial)

In consideration of the services rendered, you agree to pay Celebration Obstetrics and Gynecology in accordance with the regular rates and terms of service/costs for Celebration Obstetrics and Gynecology. Unless prior arrangements have been made, payment is due in full at the time services are rendered. You affirm that you are duly authorized as the patient or as patient's guardian/agent to execute this document and accept its terms.

Self-Pay: (initial)

Patient's certification authorization to release information and payment request. You certify the information given to Celebration Obstetrics and Gynecology in applying for payment under Title XVIII/XIX of the Social security act is correct. You authorize any holder of medical or other information about you to release to Social Security Administration/Division of Family services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. You further certify all insurance proceeds pertaining to treatment or services provided shall be assigned to Celebration Obstetrics and Gynecology.

Medicare/Medicaid: (initial)

We collect and send specimens to a laboratory for processing. We are NOT responsible for laboratory charges. If you have any questions regarding the laboratory charges, you must call the laboratory listed on the bill.

Laboratory Charges: (initial)

CELEBRATION OBSTETRICS AND GYNECOLOGY

HIPPA

Health Insurance Privacy & Portability Act

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of your care and services you receive at our organization. We need this record to provide you quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us To:

1. Keep your medical information private.
2. Give you this notice describing your legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, providing that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

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410 CELEBRATION PLACE, STE 208
CELEBRATION, FLORIDA 34747
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FAX 407-566-2499

WWW.CELEBRATIONOBSGYN.COM

2209 NORTH BOULEVARD WEST STE C
DAVENPORT, FLORIDA 33837
TELEPHONE 863-424-4321
FAX 407-566-2499

ACKNOWLEDGEMENT FORM

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name: _____

Patient Signature: _____

Date: _____

Witness: _____