Gynecologic Surgeons & Obstetricians, P.C.

Patient Registration Information

Patient Information

Last Name _____ First Name _____ M.I. ____ Date of Birth _____

Street Address _____ City _____ State _____ Zipcode _____

SSN _____ Marital Status _____ Phone Numbers (check preferred)

☐ H: _____

☐ M: _____

Email Address _____

Contact Preference ☐ Voice ☐ Email ☐ Text ☐ Patient Portal ☐ Do Not Contact

Current Employer _____ Job Title _____ Work Phone _____

Referring Physician _____

Race/ Ethnicity: ☐ Caucasian ☐ Hispanic/Latino ☐ African American ☐ Asian ☐ Native American ☐ More than One Race ☐ Unknown ☐ Not Reported – Refused ☐ Other Race:_____

Primary Language: ☐ English ☐ Spanish ☐ Other (Please Specify):_____

Spouse / Significant Other / Parent or Legal Guardian Information

Name _____ DOB _____

Address _____ SSN _____

Employer _____ Phone _____

Emergency Contact

Name and Relationship _____ Phone _____

Insurance Information

Primary Ins:_____ Name of Insured: _____ DOB: _____

Policy # _____ Group # _____

Secondary Ins:_____ Name of Insured: _____ DOB: _____

Policy # _____ Group # _____

Consent to access pharmacy history: ☐ Yes ☐ No

Payment for services is due in full on the day of your visit unless insurance coverage is in effect. Financial arrangements should be made with the Billing Department prior to surgical or obstetrical care. I understand that:

- My insurance coverage is a contract between me and my insurance company.
- I am responsible for payment of copays, deductibles, & services or items not considered covered benefits.
- I am responsible for obtaining any referrals or authorizations required by my insurance company.
- I am responsible for unpaid balances.

My signature below authorizes my consent for treatment. I have received a copy of Gynecologic Surgeons & Obstetricians, P.C.'s Notice of Privacy Practices, which describes how my health information may be used or disclosed. I assign benefits and authorize payment directly to Gynecologic Surgeons & Obstetricians, P.C. for any medical or surgical services.

Patient Signature_____ Date _____

****Please have your insurance cards and photo I.D. ready for photocopying****

Medical Information Release Form for Gynecologic Surgeons & Obstetricians, P.C.

HIPAA RELEASE FORM

AUTHORIZATION WHEN PATIENT REQUESTS DISCLOSURE OF PROTECTED HEALTH INFORMATION

☐ I hereby authorize Gynecologic Surgeons & Obstetricians, P.C. to disclose any or all medical information concerning my injuries, disabilities, and physical condition, including all medical records and radiographs, pictures, or other information including any condition or care related to any drug and/or alcohol dependency, psychological diagnosis, or HIV or AIDS status to:

☐ Spouse_____

☐ Significant Other _____

☐ Parent(s) _____

☐ Child(ren) _____

☐ Other _____Relation:_____

☐ My personal health information is NOT to be released of disclosed to anyone.

This authorization expires upon written notice from me. I understand I have a right to revoke this authorization in writing except to the extent Gynecologic Surgeons & Obstetricians, P.C. has taken action or has relied upon authorization. The authorization may be revoked in writing delivered to Gynecologic Surgeons & Obstetricians, P.C.

The information used or disclosed under this authorization may be subjected to redisclosure by the recipient and no longer protected by federal privacy laws.

_____	_____	_____
Date Signed	Patient Signature	Date of Birth
_____	_____	_____
Date Signed	Signature of Personal Representative of Patient	Relationship

Acknowledgement of Privacy Practices

I acknowledge that I have been notified of Gynecologic Surgeons and Obstetricians, P.C.'s Notice of Privacy Practices which describes how my health information may be used or disclosed. I understand Gynecologic Surgeons and Obstetricians, P.C. reserves the right to change the notice and its privacy practices at any time. Copies of the Notice of Privacy of Practices are located on the front desks of Gynecologic Surgeons and Obstetricians, P.C.'s, if I would like a copy they are available at the front desk.

_____ _____

Signature of Patient/Responsible Party Date

_____

Print Name

Patient unable to sign because _____

Good Faith Effort

- Presented the Notice of Privacy Practices to the patient/responsible party, but the patient/responsible party declined to acknowledge receipt.
- The Notice of Privacy Practices was mailed to the patient/responsible party.
- Other _____

_____ _____

Signature of Gynecologic Surgeons and Obstetricians, P.C. Representative

Date

Debra C. Placek, M.D.
Jeffrey E. Tomjack, M.D.
Emily M. Neri, M.D.

WOMEN'S HEALTH CARE CENTER
of Williamsburg

Rachel H. Anderson, D.O.
Todd D. Martin, M.D.
Tami L. Clark, P.A.-C
Terra N. Vejraska, A.P.R.N.

6050 Village Drive • 6120 Village Drive • Williamsburg Village • Lincoln, NE 68516-4714
(402) 421-8581 Day and Night • FAX: (402) 421-8594 • www.gsodocs.com

Patient Financial Policy

Thank you for choosing Women's Health Care Center of Williamsburg as your provider. We are committed to building a successful relationship with you. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

Co-pays

Patients are expected to present an insurance card at every visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with billing staff.

Insurance Claims

Insurance is a contract between you and your insurance company. We will bill your primary insurance as a courtesy to you. In order to properly bill your insurance, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient being responsible for the entire bill. Although we may provide you an estimate of what your insurance may pay, we cannot be responsible for any discrepancy between what the insurance company quotes to us and what they actually pay. If your insurance company pays you directly, you are responsible for payment and agree to forward payment to us immediately.

Referrals and Preauthorizations

Certain insurances require that you obtain a referral or prior authorization prior to service. If you are a new patient and need a referral or preauthorization prior to seeing our providers, you will be responsible for obtaining this. If you are an established patient and need a preauthorization prior to services, we will attempt to obtain this as a courtesy to you. However, if we are unable to secure a preauthorization, or your insurance company gives us incorrect information, you are responsible for payment. We cannot be responsible for any discrepancy between what the insurance company quotes to us and what they actually pay. When service is performed at an outside facility, it is patients responsibility to know which facilities are in their network.

Self-pay accounts

Self pay accounts are patients without insurance coverage, or without an insurance card on file. While we participate with most plans, it is always the patient's responsibility to know if our office is participating with your plan. If there is a discrepancy with our information, the patient will be considered self pay until resolved. Self pay patients will be required to pay an estimated office visit fee upon their first visit and will be responsible for prompt payment of any additional charges incurred, or an acceptable payment arrangement with our billing office. Please ask to speak to the billing office to discuss a mutually agreeable payment plan.

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Cancellation of appointments

If it is necessary to cancel an appointment, please give us a minimum of 24 hours advance notice.

Repeatedly missing scheduled appointments jeopardizes your care. For this reason, new patients may be discharged from the practice for 1 no show or failure to cancel appointment and established patients may be discharged from the practice for 2 no shows or failure to cancel appointments.

Completion of Forms

In order to better serve you, we request that you are aware of the following:

Payment is required prior to completion of all forms. Fees are available upon request. Please allow 10 business days for completion of forms.

Returned checks

The charge for a returned check is $35 payable by cash or credit card. This will be applied to your account in addition to the insufficient funds amount.

Outstanding balance policy

It is our policy that all past due accounts receive three statements. If payment is not made, a phone call and letter will be made to try to make payment arrangements. Once payment arrangements have been made, we must have consistent payment. If no resolution can be made, the account may be sent to the collection agency, along with possible discharge from the practice.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact the business office.

Women's Health Care Center of Williamsburg reserves the right to change or modify this information at any time. By signing this form, patient acknowledges having read and agreeing to policy.

Patient:_____ Date:_____

1/1/2020

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