LEXINGTON OB GYN
GEORGETOWN OBGYN ASSOCIATES

1

REGISTRATION FORM

Appointment Date: ____________ Doctor being seen: ______________ Primary Care Provider: ______________

PATIENT INFORMATION

Patient's Name

Last: ______________________ First: ______________________ Middle: ____________

Marital Status (Circle): Single Married Divorced Separated Widow

Birth Date: ______________ Age: ________ Social Security #: ______________________

Address: ____ Apt. #: ________

City: ______________________________ State: ______ ZIP Code: ____________

Home Phone #: (_____) ______________________ Cell Phone #: (_____) ______________________

Email Address: ____

Preferred Pharmacy: ______________ Location: ______________ Phone #: ______________

Occupation: ______________ Employer: ______________ Employer Phone #: (_____) ________

Spouse's Name: ______________________________ Spouse's Birthday: ____________

Spouse's Employer: ______________________ Spouse's Employer's Phone #: (_____) ________

Other family members seen here: ____

2

INSURANCE INFORMATION

Please indicate primary insurance: ______________________ Insurance Phone #: ______________

Subscriber's Name: ____

Subscriber's S.S. #: ____________ Birth Date: ________ Group #: ________ Policy (ID) #: ____________

Co-Payment: $ ______________

Patient's Relationship to Subscriber (Circle): Self Spouse Child Other

Name of secondary insurance (if applicable): ____________ Insurance Phone #: ______________

Subscriber's Name: ____

Subscriber's S.S. #: ____________ Birth Date: ________ Group #: ________ Policy (ID) #: ____________

Co-Payment: $ ______________

Patient's Relationship to Subscriber (Circle): Self Spouse Child Other

I certify that I have no other insurance other than what I listed above ______________________.

3

IN CASE OF EMERGENCY

Name of Contact: ______________________________ Relationship to Patient: ______________

Home Phone #: (_____) ____________ Work Phone #: (_____) ____________ Birth Date: ____________

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The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lexington OBGYN Associates or insurance company to release any information required to process my claims.

Patient/Guardian Signature ______________________________________ Date ______________

Dear Patients:

Lexington OB GYN Associates has always protected the confidentiality of health information by keeping medical records away from the public and refusing to reveal health information about you to anyone other than those to whom you authorize us to release information. Today state and federal laws have been enacted to ensure confidentiality of your health information.

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects the health information that is maintained by physicians, hospitals, other health care providers and health care plans. The effective date of these laws is April 14, 2003.

The new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or submit a health claim to a health plan, your physician, the hospital or other health care provider must follow the privacy rules.

The privacy rule also provides you with certain rights, such as the right to have access to your medical records. There are exceptions; these rights are not absolute. We will take precautions in our office to protect your health information such as training our employees and employing other measures to secure your privacy. Please be understanding of the need to enforce these regulations.

The Notice of Privacy Practices attached to the letter explains our practices. The form that follows is specific to our practice and allows you to outline your desires. Please complete it carefully as it becomes part of your medical record.

If you have any questions regarding this policy, please contact our privacy officer, Beth Owen at 859-278-0396.

Thank you,

The Physicians and Staff of Lexington OB GYN Associates

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

CONSENT TO WIRELESS TELEPHONE CALLS: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the office to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial technology, or by electronic mail, text messaging or by any other form of electronic communication from the office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

CONSENT TO EMAIL USAGE: If at any time I provide an email address at which I may be contacted, unless I notify the office to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from the office.

➧ Patient's Signature ______________________________ Date ______________

I have received Lexington OB GYN Associates Notice of Privacy Practices.

➧ Patient's Signature ______________________________ Date ______________

I understand Lexington OB GYN Associates will use my private health information only for the purposes of treatment, payment or health care operations related to the care I receive in this office. Other uses of my private information will require written authorization.

➧ Patient's Signature ______________________________ Date ______________

I authorize Lexington OB GYN Associates to release information to my health insurance company regarding services rendered. I will allow a photocopy of my signature to be used to file my insurance.

➧ Patient's Signature ______________________________ Date ______________

I authorize and direct my insurance company to issue payment for benefits due me for services rendered by Lexington OB GYN Associates directly to them. Regardless of my insurance benefits, if any, I understand I am responsible for the payment for services rendered.

➧ Patient's Signature ______________________________ Date ______________