Rebirth OB/ GYN

Client Registration

Legal Name **Last**	**First**	**Middle Initial**	**Preferred Name**

Legal Sex **Female** **Male** ***While Rebirth OB/GYN recognizes diverse gender expressions/ sexes, many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and legal correspondence. If your preferred name and pronouns are different from these, please let us know.	**Preferred Pronouns:**

Date of Birth **Month Day Year** **/ /**	**Preferred Phone** **( )**	**Preferred Phone** **( )**

Home Address	**City**	**State**	**Zip**

Billing Address (*If different from above)*	**City**	**State**	**Zip**

Email Address	**Social Security #**

Emergency Contact	**Phone Number**	**Relationship**
	( )	

If you are under 18, the Department of Public Health requires that you provide parent / guardian contact information:

Parent/ Guardian Name	**Phone Number**	**Relationship**
	( )	

This information is for demographic purposes only and will not affect your care.

Preferred Language **_____** **Country of Birth** **USA** **Other:** **_____**	**Race** **African American/Black** **Asian** **Caucasian** **Multi-Racial** **Native American/Alaskan** **Native/Inuit** **Pacific Islander** **Other:**	**Ethnicity** **Hispanic/ Latino/ Latina** **Not Hispanic/ Latino/ Latina** **Other:**

Have you seen Dr. Luikenaar before? Yes, I have seen her at the (circle below): Greenwood Clinic OB/GYN Assoc. No, I have never seen Dr. Luikenaar before?	**Where did you hear about Rebirth OB/GYN?**

Rebirth OB-GYN Fee Agreement

Rebirth OB-GYN is committed to providing you with quality and affordable health care. Please read this payment policy and sign in the space provided. Also be aware that we require ***Proof of Insurance*** (if applicable) and ***Valid ID*** at check- in for every visit.

Insurance:
We are contracted with many insurance plans. Under these plans the ***Patient*** or ***Responsible Party*** may be required to pay deductible, co-pays, or co-insurance for goods and services. It is ***YOUR*** responsible to know your insurance plan benefits and what is covered. We submit our services to your insurance company as a ***courtesy*** to you, but you are responsible for the balance of the account. Prior authorizations may be completed at the discretion of Dr. Luikenaar and we cannot guarantee that all services and medications recommended are covered. Co-pay and deductibles are due at the time of service. If a services is not covered by your plan or you don't have a valid insurance card, payment is due at the time of service. We accept all credit cards, cash and checks. A $30 Fee will be assessed for any returned checks.

Missed Appointments:
Missed appointments or cancelled appointments within 24 hours will be billed directly to you; $25 for return patients and $50 for new patients. Any no show fee need to be paid prior to rescheduling your next appointment.

Non-Payment:
Balances over 120 days due may be sent to a collection agency unless other arrangements have been made. You may also be discharged from the practice.

Other charges may occur for forms and letters on your behalf and may need to be completed in person during any appointment at the clinic.

Prescriptions:
There will be a $10 fee charged for any duplicate replacement of written prescriptions.

I have read, agree and understand the above policies and accept these responsibilities.

_____ ***Patient / Responsible Party,*** _____ ***Date***

_____ ***Witness (Rebirth OB-GYN),*** _____***Date***

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Rebirth OB/GYN or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing the consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. Rebirth OB/GYN may or may not agree to restrict the use of disclosure of your protected health information.
If Rebirth OB/GYN agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Rebirth OB/GYN reserves the right to modify the privacy practices out-lined in the notice.

Signature

I have reviewed this consent form and give my permission to Rebirth OB/GYN to use and disclose my health information in accordance with it.

_____
Name of Patient (Please Print)

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative (Under 18) Date

_____
Relationship of Patient Representative to Patient

_____
Other person(s) we may share information with (i.e. lab results, billing, medical information).