PAUL W. MORRISON, M.D.
OBSTETRICIAN + GYNECOLOGIST

SSN_____ **Birth Date**_____

Patient Name_____
(Last) (First) (MI)

Address_____City_____State_____Zip_____

Cell/Home Phone_____ Work Phone_____ Email_____

Employer_____Occupation_____

Emergency Contact_____Phone_____

Relationship to Patient_____ Primary Care Physician_____

Insurance Information
(Policy Holder= who carries the Insurance on the patient)

Insurance Name_____ Policy Holder Name_____

Policy ID_____Policy Holder DOB_____

Group Number_____ Policy Holder SSN_____

Policy Holder Employer_____

Secondary Insurance

Insurance Name_____ Policy Holder Name_____

Policy ID_____ Policy Holder DOB_____

Group Number_____ Policy Holder SSN_____

Policy Holder Employer_____

Guarantor Info (Person/ Persons responsible for payment/ insurance)

Name_____Date of Birth_____

Address_____City_____State_____Zip_____

Cell/Home Phone_____ Work Phone_____

Consent for Release of Information

Insurers may release to Dr. Paul Morrison LLC any information regarding the extent of my insurance coverage, information concerning the status of claims submitted by Dr. Paul Morrison LLC and information regarding payments made directly to me on those claims. Dr. Paul Morrison LLC may obtain any information and/or medical records pertinent to "treatment" provided from hospitals, physicians, nursing agencies, and other health care providers. Pursuant to the privacy rule 45CFR164.501 of HIPAA, "treatment" generally means the provision, coordination, or management of health care and related services among providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

Assignment of Benefits

I hereby assign all medical benefits to which I am entitled to Dr. Paul Morrison LLC. This applies for all insurance carriers, including Medicare, private insurance, and any other health/medical plan**. I understand that it is my responsibility to report any changes in insurance coverage.** I understand that I/patient am responsible for charges incurred regardless of whether my insurance pays or not. I/patient also understand that I am responsible for any attorney fees and court costs incurred in collecting any unpaid balances for services I/patient received. I consent to medical treatment and I authorize this office to release medical records or pertinent information necessary to determine benefits entitlement and to process payment. I agree that this statement applies to all current and future claims.

Payment at Time of Service

Your clear understanding of our financial policy is important to our professional relationship. Please understand payment of your bill is vital to our ability to continue to provide medical care within the community. As a courtesy to you, we bill your insurance directly for the services you receive from us. As a standard practice, we collect all expenses that are the responsibility of the patient at the time of service. Our request for payment will include any deductible, co-pay and coinsurance amounts that apply to your visit/procedure.

In some cases, the amount of charges is an estimate based upon information provided directly by your insurance company regarding your particular plan, eligibility, and the procedures performed. However, the exact amount of all charges may not be known at the time of service as your insurance may process differently than anticipated. It is possible additional expenses that are the responsibility of the patient may be reflected on your final statement. In such a case, the payment collected at the time of service serves as a deposit towards your final balance. In order for us to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including cell phone numbers, which could result in charges to you. If the patient provides Dr. Paul Morrison LLC or its agents with his/her cell phone number, the patient authorizes Dr. Paul Morrison LLC or its agents to call his/her cell phone either manually or by auto-dialer in order to collect any amounts the patient owes. Additionally, any overpayment will be promptly refunded to you after all claims have been processed by all applicable payers.

Dr. Paul Morrison LLC will charge a $30 fee for check payment returned by the bank for non-sufficient funds or closed account.

Cancellation / No-Show / Late Policy

We strive to provide the best care to our patients. We schedule your visits according to care plans that optimize your wellness outcomes. Making your appointment as scheduled is very important, not just for us, but for you. While we are not fond of the negative connotation of any cancellation policy, we believe such a policy is in the best interest of accommodating all of our patients who are dedicated to improving their wellbeing.

If negative circumstances require you to cancel a scheduled appointment, we request you do so at least 48 hours in advance. If you must cancel your appointment, fail to show up for your appointment, or are late for your appointment more than two times you will be discharged from our practice.

If you are an established patient and you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

Likewise if you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

The same terms will apply if you arrive late to an ultrasound appointment. You may be asked to reschedule at the discretion of the sonographer. We ask that you please be courteous of your provider's valuable time and attention. The physicians, office staff, as well as your fellow patients will thank you.

By signing below, I understand and agree to the terms of the above Consent for Release of Information, Assignment of Benefits, Payment at Time of Service Policy and Cancellation/No-Show/Late Policy.

Signature_____ Date_____

Authorization for Disclosure

I, a patient of Dr. Paul Morrison LLC, give my expressed permission to discuss with the individual(s) I have listed:

Please check appropriate box(es): □ Any aspect of my health care □ Health information only □ Financial information only

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

Name: _____Relationship: _____ Phone: _____

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Signature_____Date_____

I/patient choose to receive communication from Dr. Paul Morrison LLC by text, phone call, or email at the number stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such communications may not be secure and there is a risk that they may be read by a third party.

Signature_____ Date_____

I/patient acknowledge receipt of the Notice of Privacy Rights and Practices and have been given the opportunity to review that notice.

Signature_____ Date_____