ADVANCED OB-GYNE ASSOCIATES

REGISTRATION ACCT#____________ DATE______________

PATIENT'S NAME________________________ DATE OF BIRTH________________
MARITAL STATUS: SINGLE________ MARRIED________ DIVORCED________

STREET ADDRESS ________________________HOME PHONE________________
CELL PHONE________________SAME AS HOME YES NO (CIRCLE)
EMAIL ________________
CITY________________________ STATE__________ ZIP__________
SOCIAL SECURITY NUMBER________________ DRIVER'S LIC # ________________
EMPLOYER________________________ HOW LONG________________
PRESENT POSITION ________________________
STREET ADDRESS ________________________ PHONE ________________
CITY________________________ STATE________ ZIP________________
ETHNICITY________________________ RACE________________
LANGUAGES SPOKEN____
IF UNDER 18, PARENT OR LEGAL GUARDIANS NAME________________________

HUSBAND'S NAME________________________ DATE OF BIRTH________________
HUSBAND'S SOCIAL SECURITY NUMBER________________ YEARS MARRIED________________
HUSBAND'S EMPLOYER________________________ HOW LONG________________
PRESENT POSITION________________________
STREET ADDRESS________________________ PHONE________________
CITY________________________ STATE________ ZIP________________

PURPOSE OF APPOINTMENT____
IN CASE OF EMERGENCY, WHOM TO NOTIFY (OTHER THAN SPOUSE):
NAME________________________ RELATIONSHIP________________
PHONE________________________

PRIMARY INSURANCE INFORMATION, IF APPLICABLE

NAME OF INSURANCE CO.________________________ ID# ________________
*NAME OF INSURED________________________ GROUP # ________________
ADDRESS OF INSURANCE CO. ________________________ PHONE ________________
CITY________________________ STATE________ ZIP________________
*IF PARENT: SOCIAL SECURITY NUMBER________________________DOB:________________

SECONDARY INSURANCE, IF APPLICABLE

NAME OF INSURANCE CO.________________________ ID# ________________
*NAME OF INSURED________________________ GROUP # ________________
ADDRESS OF INSURANCE CO. ________________________ PHONE ________________
CITY________________________ STATE________ ZIP________________

OTHER

PRIMARY CARE PHYSICIAN (PCP): ________________________PHONE________________
ADDRESS________________________CITY________________STATE______ZIP__________
PREFERRED PHARMACY________________________PHONE________________
WHOM MAY WE THANK FOR REFERRING YOU________________________________

COMMENTS____
____

ASSIGNMENT, AUTHORIZATION, POWER OF ATTORNEY AND AGREEMENT

In that the office is, waiting for the payment of some of its fees, I agree to provide the office with information and forms regarding any potential source of fee payment, to assist in any way I can and;

I hereby assign to this office the benefits that I am eligible to receive for the care rendered in this office. In consideration of this assignment the office extends credit.

Insurance payments should be payable to and mailed to: Advanced Ob-Gyne Associates, S.C., 1555 N Barrington Rd, Ste 425, Hoffman Estates, IL 60169-5020. Patient payments should be payable to and mailed to: Advanced Ob-Gyne Associates, S.C., 1555 N Barrington Rd, Ste 425, Hoffman Estates, IL 60169-5020.

I fully understand and agree that the insurance policies are an agreement between an insurance carrier and myself. I will be responsible for any and all expenses not paid by insurance.

I appoint this office as attorney-in-fact to correspond on my behalf with insurance companies, to negotiate any settlement and to cash any settlement draft or check, to counsel and advise insurance companies that no settlement can be effectuated without the agreement of this office or the office's release of specific provision.

I fully understand that payment-in-full is expected at the time of service unless previous arrangements have been made with an authorized manager, or my appropriate co-payment amount is paid at the time of service and my full charges are billed to the office's contracted insurance carrier. If specific tests are requested by me I will sign the required waiver, make appropriate deposit and be responsible for any unpaid balances in accordance with said waiver.

I fully understand and agree to be responsible for any legal interest on the indebtedness, together with such collection costs, including but not limited to investigation fees, skip tracing fees, credit report fees, court reporter fees, service of process fees, filing fees, and reasonable attorney fees as my be required to effect collection. An administration fee will be assessed to my account if my account is sent for collections.

I understand that if this office receives more than my deposit, the office will pay any credit balances to me by corporation check or credited back to my credit card.

I hereby grant permission to the doctor and/or authorized personnel to administer medication and perform such procedures as may be deemed necessary in the interest of my health.

A finance charge/interest charge will be assessed to my account if the full balance is not paid within the normal billing cycle of 30 days. Fees for services are subject to change without prior notice.

I authorize medical records (PHI) and/ or receipts to be sent to me via the internet (email/fax/scan).

A photocopy of this form shall be considered as valid as the original.

Patient Signature______________________________ Date______________

**Responsible party (If under 18)______________________________ Date______________