West Coast Obstetrics & Gynecology

Michele LeMay MD, Karen Matta-Toomey MD, John David Hansill MD, Rosabelle Campos MD
513 Manatee Ave E Bradenton FL 34208
Phone 941-745-1616 Fax 941-748-1897

Registration Form

Patient Name:_____ Nickname:_____

Address:_____

City, State, Zip:_____ Marital Status:_____

Date of birth:_____ Age:_____ Social Security #:_____

Home Ph:_____ Work Ph:_____ Cell Ph:_____

Primary Doctor:_____ Pharmacy:_____

Employer:_____ Occupation:_____ How long:_____

Allergies:_____

Email:_____

Insurance Company:_____ Insurance I.D._____

Insurance Card Holder (please check one) SELF ( ) SPOUSE ( ) OTHER ( ):_____

Primary Insured Name:_____ DOB:_____ SS#_____

Spouse name:_____ Occupation:_____ Work Ph: (____)_____

Guardian / Parent Information If Patient is a Minor:

Name of parent(s):_____ Relationship:_____

Social Security#:_____ Date of Birth:_____

Home Ph: (_____)_____ Work Ph:(_____)_____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper. I request that payment of authorized insurance company benefits be made either to me or on my behalf to West Coast OB/GYN for any services furnished to me by that party who accepts assignments; physician regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party that accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (section 11288 of the Social Security Act and 31 U.S.C 3801-3812 provides penalties withholding this information).

SIGNATURE:_____ **DATE:**_____

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I wish to be contacted in the following manner (check all that apply):

( ) HOME TELEPHONE

[] LEAVE DETAILED MESSAGE
[] LEAVE CALL BACK NUMBER ONLY

( ) WORK TELEPHONE

[] LEAVE DETAILED MESSAGE
[] LEAVE CALL BACK NUMBER ONLY

( ) CELL PHONE

[] LEAVE DETAILED MESSAGE
[] LEAVE CALL BACK NUMBER ONLY

( ) WRITTEN COMMUNICATION

[] MAIL TO HOME ADDRESS
[] MAILTO WORK ADDRESS

( ) RELEASE TO IMMEDIATE FAMILY

[] LEAVE DETAILED MESSAGE
[] LEAVE CALL BACK NUMBER ONLY

( ) FAX THIS NUMBER_____

[] LEAVE DETAILED MESSAGE
[] LEAVE CALL BACK NUMBER ONLY

Emergency contact to leave call back information (if unable to reach you):

NAME_____RELATIONSHIP_____

PRIMARY PHONE NO._____ALTERNATE PHONE NO._____

I UNDERSTAND THAT ALL PERSONAL RECORDS AND INFORMATION IS KEPT CONFIDENTIALLY THROUGH WEST COAST OB/GYN. THE ABOVE INFORMATION IS APPROVED BY MY PERSON.

PATIENT SIGNATURE_____ DATE_____

PRINT PATIENT NAME_____ DOB_____

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Patient Authorization For Use And Disclosure Of Protected Health Information

BY SIGNING THIS AUTHORIZATION, I AUTHORIZE WEST COAST OB/GYN TO USE AND/OR DISCLOSE CERTAIN PROTECTED HEALTH INFORMATION (PHI) ABOUT ME. THIS INFORMATION MAY INCLUDE INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION SUCH AS DATES OF SERVICE, TYPE OF SERVICES, LEVEL OF DETAIL TO BE RELEASED, ORIGIN OF INFORMATION, AND ANY/ALL TREATMENT.

THE INFORMATION SHALL BE USED OR DISCLOSED FOR THE FOLLOWING PURPOSE:

_____ **Request of Patient**

_____ Patient is a Minor

_____ Other _____

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM DATE SIGNED

IT MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPENT AND MAY NO LONGER BE PROTECTED BY THE FEDERAL HIPPA PRIVACY RULE. I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ACTED IN RELIANCE UPON THIS AUTHORIZATION. MY WRITTEN REVOCATION MUST BE SUBMITTED TO THE PRIVACY OFFICER AT:
513 MANATEE AVE E, BRADENTON, FL 34208

Patient Signature: _____ **Date:** _____

Patient Name: _____

PERSON(S) TO WHOM INFORMATION MAY BE RELEASED:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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Financial Policy

We are here to provide you the highest quality care. Your clear understanding of our professional fees is important. Please understand as your health care providers, we are committed to you, not your insurance company.

Please review our policy:

- Payment is due at time of service, including co-payments and deductibles
- We accept cash, checks, Visa, Mastercard, and Discover
- It is **your** responsibility to verify our participation with **your** health insurance plan
- Please make sure your insurance plan covers the services provided by us
- It is **your** responsibility to provide us with correct and complete insurance information
- Your insurance card is needed at the time of check-in in order for us to provide you care
- Please inform our office of any changes in your insurance
- Failure to notify us at least 24 hours in advance of appointment cancellation will result in a $35.00 charge

I agree to the financial policy explained above.

Patient Signature: _____ **Date:**_____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I have seen a copy of the West Coast Ob/Gyn Notices of Privacy Practice

(Located on office bulletin board)

Patient Signature_____ **Date**_____

Print Name _____

WEST COAST
OBSTETRICS & GYNECOLOGY

EFFECTIVE MARCH 7, 2018

Missed Appointment Policy

A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 48 business hours.

Remember this time was reserved especially for you, therefore, we request at least 48 business hours' notice in order to utilize this time for another patient.

If you are unable to keep your scheduled appointment, please call our office at least 48 business hours in advance to avoid a missed appointment fee of **$35** for Office Visits, **$75** for Procedures and **$50** for Ultrasounds.

This charge is NOT covered by insurance.

Also, we ask that you arrive on time for your appointments. When you arrive late for an appointment we may have to reschedule you to another day.

Patient Signature: _____

Please print name: _____

Date Of Birth: _____