coastal
obstetrics &
gynecology

**NAME**_____**BIRTHDATE**_____

**NICKNAME**_____**SS#**_____-___-_____**ETHNICITY**_____

**ADDRESS**_____

**CITY,STATE**_____**ZIPCODE**_____

**HOME#**_____**WORK#**_____**CELL#**_____

**EMAIL**_____**PHARMACY NAME/LOCATION**_____

**OCCUPATION**_____**EMPLOYER**_____

**SINGLE**_____**MARRIED**_____**OTHER**_____**PARTNER'S NAME**_____

**PARTNER'S EMPLOYER**_____**PARTNER'S #**_____

**PERSON RESPONSIBLE FOR INSURANCE**_____**BIRTHDATE**_____

**EMERGENCY CONTACT**_____**#**_____

**PRIMARY CARE PHYSICIAN**_____ _____

**HOW DID YOU HEAR OF COASTAL?**_____

**THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO COASTAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE COASTAL OR MY INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.**

**SIGNATURE**_____**DATE**_____

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA): I ACKNOWLEDGE THAT I HAVE READ OR WAS GIVEN THE OPPORTUNITY TO READ IF I CHOSE AND UNDERSTAND THE NOTICE.**

**PRINT NAME**_____**DATE**_____

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**PATIENT NAME**_____**BIRTHDATE**_____

**I ACKNOWLEDGE THAT IF, FOR SOME REASON, MY INSURANCE COMPANY DOES NOT PAY FOR MY VISITS/TREATMENT, OR IF MY VISITS/TREATMENTS ARE NOT COVERED BY MY INSURANCE, THEN I AM RESPONSIBLE FOR FULL PAYMENT OF THE CHARGE. IF I DO NOT PAY THE CHARGE IN A TIMELY FASHION AND IF I AM SENT TO COLLECTIONS THEN I ACKNOWLEDGE THAT A 15% FEE WILL BE ADDED TO COVER THE COLLECTION COMPANY'S FEE. THIS IS TRUE EVEN IF I DO NOT HAVE INSURANCE BUT HAVE RECEIVED SERVICES BY THE PRACTIONERS AT COASTAL OB/GYN.**

**SIGNATURE**_____**DATE**_____

**I ACKNOWLEDGE THAT IF I HAVE A BALANCE I MAY BE ASKED TO PAY IT IN FULL (UNLESS A PAYMENT PLAN HAS BEEN ARRANGED BY ME WITH THE BUSINESS OFFICE) BEFORE I AM ABLE TO MAKE AN APPOINTMENT FOR A VISIT/SERVICES AT COASTAL OB/GYN.**

**SIGNATURE**_____**DATE**_____

**GIVEN THE NATURE OF OBSTETRICS I UNDERSTAND THAT THE PRACTIONERS MAY, IN AN EMERGENCY, NEED TO CANCEL MY VISIT—I UNDERSTAND THAT I WILL BE OFFERED A VISIT WITH ONE OF THE OTHER PRACTIONERS ON THAT DAY IF POSSIBLE OR ON ANOTHER DATE IN A TIMELY MANNER.**

**SIGNATURE**_____**DATE**_____

**I UNDERSTAND THAT I NEED TO INFORM COASTAL AT LEAST 24 HOURS BEFORE I CANCEL MY APPT AND THAT IF I DO NOT DO SO I MAY BE CHARGED A $25.00 FEE GIVEN THE "MISSED" VISIT.**

**SIGNATURE**_____**DATE**_____

**I AUTHORIZE COASTAL TO CONTACT ME THROUGH CELL/WORK/HOME NUMBERS OR TO SEND INFORMATION TO MY HOME ADDRESS WHEN NECESSARY.**

**SIGNATURE**_____**DATE**_____

**I GIVE MY PERMISSION TO COASTAL OB/GYN TO RELEASE MEDICAL INFORMATION TO MY OTHER DOCTORS AND FACILITIES WHEN DEEMED NECESSARY**

**SIGNATURE**_____**DATE**_____