PATIENT REGISTRATION FORM

PLEASE PRINT **DATE:**______________________

Name:____ Date of Birth:_____________Age:________

Address:____Apt:______________

City:_____________________________________State:_____________Zip:___________________

Home Phone Number: ( )__________________Cellular: ( )______________________________

Marital Status: (M) (S) (W) (D) Ethnicity:____________________________Race:__________________

Social Security Number: _______-______-______E-Mail Address:____________________________

Employer / Business: ___________________________________Occupation: ___________________

Employer Phone:_________________________________

Preferred Pharmacy:____

EMERGENCY CONTACT INFORMATION

Name: _______________________________________ Relationship: ________________________

Phone:_______________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE:____

Member ID Number: ____________________________________Group:________________________

Policy holders name:___________________________________D.O.B.________________________

Policy Holder SSN:________________________________Relationship to Patient: _________________

SECONDARY INSURANCE:____

Member ID Number: ____________________________________Group:________________________

Policy holders name:___________________________________D.O.B.________________________

Policy Holder SSN:________________________________Relationship to Patient: _________________

How did you hear about Aurora OB/Gyn Associates?

[ ] Family [ ] Friend [ ] Co-Worker [ ] Health Plan / Insurance Directory

[ ] Physician [ ] Other

Person who referred you:____

Rescheduling / Children Policy

- If you need to cancel or reschedule an appointment, we ask that you give at least 24 hours' notice if possible. This allows us to manage our office schedule more efficiently, and also makes it possible to see a patient who may have an acute problem, but might have been unable to get an appointment on that day. No appointments will be rescheduled after regular office hours. Our answering service is unable to see our schedules. Three or more such occurrences may be cause for termination of care through our office.

- Children Policy. As Parents and Obstetricians, we adore children. As your physician, we are concerned about typical childhood diseases and the health effects they could have with other patients, expectant mothers and their unborn child. Bringing small children into the office can also expose them to biohazardous materials. We ask that you make childcare arrangements for your children prior to your office visit. We deeply understand the inconvenience that this may cause. However, the health and safety of all our patients must be our primary concern.

Thank you for your cooperation.

Signature: ____________________________________ Date: ______________________

Karen T. Allsup, M.D. ,FACOG
3303 Rogers Rd. Ste. 100
San Antonio, TX 78251
Ph. 210-547-4700

FINANCIAL POLICY

Thank you for choosing Aurora Ob/Gyn Associates as your health care provider. We are committed to providing you the best available medical care. Our personnel will be happy to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy as well as complete our Patient Registration Form prior to seeing the physician

Payment for service is due at the time services are rendered. We accept cash, check, VISA and Mastercard. We will be happy to help you process your insurance claim for your reimbursement.

In special instances, we may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and “usual and customary” charges. We are however, contracted with certain managed care, and preferred provider plans; we will follow the guidelines for patient care, reimbursement, and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
2. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover.
3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment. If you have an unpaid balance, we will reschedule your appointment, unless you make arrangements with our billing department. Co-Payments not paid at the time of service are subject to a $10.00 processing fee.
4. **Pending Medicaid** – Aurora Ob/Gyn DOES NOT retroactively bill Medicaid for services performed prior to the date of initial eligibility verification. If you have no other insurance coverage, you will be considered a self-pay patient and will be responsible for all services that you received prior to the initial eligibility date.

5. **OB Patient** – You will be given an estimated payment arrangement based on the amount of your current deductible, and the percentage of co-insurance responsibility set by our contracted rate with your insurance company. Deductibles (not met) are collected in full, along with the co-insurance responsibility. The payment arrangement must be paid in full by your 30th week of pregnancy. Any credits on OB contracts will not be returned until all claims have been processed. Refunds will be issued after an audit of the account has been completed.
6. **Lab Billing** – Please remember, your lab billing is separate from our physician's billing and you may receive a separate itemized bill from the laboratory, for which you are responsibility. Please verify that you are being directed by our office to a lab that is a participating provider with your insurance plan.
7. **FMLA** – The physician at Aurora Ob/Gyn Associates will provide you with an excuse due to medical illness with specific dates at no charge during a clinic visit. If further information, such as FMLA, Short-Term or Long-Term disability forms are to be filled out there is a $30.00 fee to fill out the paperwork this fee includes one revision. Any revision to these forms, after the first, will incur a $20.00 fee for each revision. This fee must be paid in full before we submit paperwork.
8. **Returned checks** – The amount of the check plus bank fees will be applied to the amount that the check was written for. If the balances are not collected within 45 days we will issue the check out to the attorney general.
9. **Medical Records** – Patient, Insurance Companies, and 3rd party requests will be subject to the following fees: 1 to 20 pages $25.00, $0.50 for each additional page.
   We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our patient account specialist, so that we can assist you in your management of your account.

Again, thank you for choosing Aurora Ob/Gyn Associates. We appreciate the opportunity to serve you.

Patient's Signature:____ Date: ___________

Karen T. Allsup, M.D. ,FACOG
3303 Rogers Rd. Ste. 100
San Antonio, TX 78251
Ph. 210-547-4700

HIPPA Notice of Privacy Practices
Acknowledgment and Questionnaire

- Please list family member or other persons, if any, whom we may inform about your general medical condition, your diagnosis and any billing questions (including treatment, payment and healthcare operations). **As a reminder these will be able to speak to or release any information to regarding your account.**

Name: ________________________ Relationship:___________________Phone: __________________

Name: ________________________ Relationship:___________________Phone: __________________

Name: ________________________ Relationship:___________________Phone: __________________

- Can confidential messages {i.e., appointment reminders} be left on your telephone, answering machine or voicemail?

Yes ______________ No ______________

- Please indicate if we may mail you correspondence if necessary?

Yes ______________ No ______________

By signing this form, I freely consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

____________________________________ Patient Signature

________________________ Date