

Name _____ Age _____ DOB _____
Last First MI

Address _____
Street Town/Village Zip

Home Phone# _____ Patient SS# _____ - _____ - _____

Patient Cell Phone# _____ E-Mail Address _____

Marital Status (Circle) S M W Sep Div Occupation _____

Patient Employer _____ Office Phone# _____

Spouse/Parent Name _____ DOB _____ SS# _____ - _____ - _____

Spouse/Parent Occupation _____ Employer _____

Emergency Contact _____

Phone # _____ Relationship _____

Who Referred You? _____ Family Doctor _____

Insurance Carrier _____

ID # _____ Group # _____ Phone# _____

Subscriber's Name _____ Relationship _____

DOB _____ Employer _____ Work Phone# _____

Secondary Insurance _____ Subscriber's Name _____

ID# _____ Group# _____ Phone# _____

By signing this statement I understand that my signature will be kept on file as a permanent record of assignment and I authorize direct payment of my insurance to Wyoming OB/GYN, L.L.C.. I understand that I am responsible for payment of services, co-payments, deductibles, etc. not under assignment by my insurance carrier. As a courtesy to our patients, Wyoming OB/GYN, L.L.C. will bill your insurance carrier for the services rendered to you. After 120 days from the date of service, outstanding balances will become your responsibility. **MEDICARE PATIENTS ONLY** : I have been notified by Wyoming OB/GYN, L.L.C. that, in certain circumstances, Medicare may deny payment for services. If Medicare does determine that the services are not "reasonable and necessary" and does deny payment, I agree to be personally and fully responsible for payment(s).

I hereby give my consent for Wyoming OB/GYN, L.L.C. to use and disclose private health information about me to carry out treatment, payment and healthcare operations. Wyoming OB/GYN, L.L.C.'s Notice of Privacy Practices provides a more complete description of the uses and disclosures). I have the right to review the notice prior to signing this consent. In signing this consent, Wyoming OB/GYN, L.L.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any treatment, payment and healthcare operations. This may include appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory and/or ultrasound results. Wyoming OB/GYN, L.L.C. may mail to my home or other alternative location any items that assist the practice in treatment, payment, or healthcare operations. This may include appointment reminder cards and patient statements. I have the right to request that Wyoming OB/GYN, L.L.C. restrict how it uses or discloses my information. However, the practice is not required to agree to my restriction request, but if it does, it is bound by this agreement. By signing this statement, I am consenting to Wyoming OB/GYN, L.L.C. to use and disclose my information when and where necessary. If there is an individual or individuals that you specifically DO NOT want information shared with, please name that individual or individuals below:

DO NOT SPEAK TO: _____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Wyoming OB/GYN, L.L.C. may decline to provide treatment to me.

Date: _____ Account # _____

Signature of Patient or Guardian (if minor)