GENESIS WOMEN'S CENTER, P.A

800 Medical Court East, Inverness, FL 34452 – Telephone 352-726-7667

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PATIENT HISTORY

Name:_____ Date:_____
Address:_____ E-Mail_____
City:_____ State:_____ Zip:_____ SS#:_____
Home#:_____ Cell:_____ Work:_____
DOB:_____ Age:_____ Race:_____ Ethnicity:_____ Language:_____
Occupation:_____ Employer:_____
Address:_____ Phone:_____
City:_____ State:_____ Zip:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner
Please give the following information about your husband/partner:
Name:_____ SS#:_____ DOB:_____
Occupation:_____ Employer:_____
Address:_____ Phone:_____
City:_____ State:_____ Zip:_____
In case of an emergency contact:_____
Phone:_____ Relationship:_____
Family Physician:_____ Phone:_____
Dentist:_____ Phone:_____
Preferred Pharmacy:_____ Phone:_____
How did you hear about us?_____
Who is responsible for payment?_____ Phone:_____

I will pay today by: ☐ Cash ☐ Check ☐ Credit Card

To our patients:
We ask for your attention in regards to future appointments. The volume of patients in need of care is high. In order to meet these needs, while also working toward more open access for appointment scheduling, we ask that you strive to give a minimum of a 24 hour notice for cancellations and reschedules. In an effort to improve access for all patients that show a trend in cancellations, no-show appointments, and/or reschedules with a notification after the start time of the appointment may be considered for dismissal from the practice. Initials: _____

I understand and agree that (regardless of insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I certify the information contained on this form is true and correct to the best of my knowledge. I will notify Genesis Woman's Center, P.A. of any changes in my health status or the above information.

Signature:_____ Date:_____

Parent Signature (if minor)_____ Date:_____

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Patient Name_____ Date of Birth_____

PATIENT FINANCIAL AGREEMENT

1. _____(Patient or Guardian Initials)

   Financial Agreement.
   - I acknowledge, that as a courtesy, GENESIS WOMEN'S CENTER may bill my insurance company for services provided to me.
   - I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by the insurance.
   - I understand that there is a fee for returned checks.

2. _____(Patient or Guardian Initials)

   Third Party Collection. I acknowledge that GENESIS WOMEN'S CENTER may utilize services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account and billing servicing.

3. _____(Patient or Guardian Initials)

   Assignment of Benefits. I hereby assign to GENESIS WOMEN'S CENTER any insurance or other third-party benefits available for health care services provided to me. I understand GENESIS WOMEN'S CENTER has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to GENESIS WOMEN'S CENTER, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____(Patient or Guardian Initials)

   Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to GENESIS WOMEN'S CENTER by the Medicare or Medicaid program.

5. _____(Patient or Guardian Initials)

   Consent to Telephone Calls for Financial Communications. I agree that, in order for GENESIS WOMEN'S CENTER, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that GENESIS WOMEN'S CENTER or EBO Servicer and collections agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or GENESIS WOMEN'S CENTER or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____(Patient or Guardian Initials)

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

Patient/Patient Representative Signature:

X_____ Date_____

If you are not the Patient, please identify your relationship to the Patient.

(**Circle or mark relationship(s) from list below):**

Spouse	**Guarantor**
Parent	**Healthcare Power of Attorney**
Legal Guardian	**Other (Please specify)** _____