Date

Advance Directives: ☐ YES ☐NO

If Yes which Hospital

Patient Information

Patient Name (Last - First - Middle) Mr. Dr. Ms. Mrs.	Gender M F	Date of Birth	Social Security No.
Address (street - City - State - Zip)	Home Phone No. ( )		Cell Phone No. ( )
City, State, Zip	Marital Status ☐ngle ☐rried ☐vorced ☐idowed		Occupation

Email Address	In Case of Emergency, Notify	Emergency Contact's Phone No. ( )
Family Physician		Family MD Phone No. ( )
Employer		Employer Phone No. ( )

We cannot guarantee insurance coverage by your insurance carrier. The information below will assist us in determining if some of the expenses are reimbursable by your HMO or insurance carrier. **Please give your insurance card to our Font Desk to be copied.**

Primary Insurance Carrier	ID #	Group #	Social Security No.
Name of Insured	Relationship to Insured	Date of Birth	Gender M F
Address (street - City - State - Zip)	Home Phone No. ( )		Work Phone No. ( )
City, State, Zip	Employer		Occupation

Secondary Insurance Carrier (if applicable)	ID #	Group #	Social Security No.
Name of Insured	Relationship to Insured	Date of Birth	Gender M F
Address (street - City - State - Zip)	Home Phone No. ( )		Work Phone No. ( )
City, State, Zip	Employer		Occupation

	I certify the above information is true and correct to the best of my knowledge. I certify that I (or my dependent) have insurance coverage and assign directly to Total Health & Wellness OBGYN LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment – and that at this time services rendered ***may not*** be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if for any reason my account is delinquent and turned over to a collection agency I am responsible for the collection agency fees and/or any legal fees.
	I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that billing is done by a third-party and that I may contact them with questions regarding my account.
	HIPPA DISCLOSURE I acknowledge that I have been provided a Notice of Privacy Practice Guidelines.

Patient / Responsible Party Signature Relationship Date