Today's Date: _____

midtown OB·GYN
MIDTOWN & NORTH

Patient's Name			**D.O.B.** / /	
Address		**City**	**State**	**Zip**
Home Phone	**Message OK? Y / N**	**Work Phone:**		**Message OK? Y / N**
Cell Phone	**Message OK? Y / N**			
Patient's SSN		**Marital Status:**		

Please check in the boxes below that you have read, acknowledge and agree:

☐ Financial Responsibility and Assignment of Insurance Benefits: I guarantee payment to MIDTOWN OBGYN of all charges for services provided. I understand that I am personally responsible for all charges not covered by my insurance company. I authorize payment of medical and surgical medical benefits which would otherwise be payable to me to MIDTOWN OBGYN for services rendered.

☐ MIDTOWN OBGYN does not do prior authorizations for medications. If your insurance company requests / requires this please provide us a copy of authorized medications.

☐ MIDTOWN OBGYN charges a $25 No Show Fee should you fail to notify us within 24 hours of your need to cancel or reschedule.

☐ MIDTOWN OBGYN charges a $25 Form Fee for all forms. Forms require 3-7 business days to complete.

☐ MIDTOWN OBGYN requires 48-72 hours for medication refill requests by phone or email.

☐ MIDTOWN OBGYN charges a $50 Fee to Reschedule Surgery once Surgery Date agreed upon.

☐ MIDTOWN OBGYN Hospital Providers have privileges only at Midtown Medical Center.

☐ I have read this form and reviewed a copy of the Notice of Privacy Practices and understand I may obtain a copy upon request. All questions relating to this form have been answered.

☐ Please be aware that if you have a problem at your Wellness/Annual Exam, there will be a copay.

Preferred Pharmacy: _____

Emergency Contact Name: _____

Emergency Contact Relationship: _____ Phone #_____

May release medical information to (please check all that apply):

☐ No One

☐ Husband: _____

☐ Mother: _____

☐ Other: _____

_____

Patient Signature