

PRAIRIE POINT OB/GYN

****** PLEASE PROVIDE US WITH YOUR INSURANCE CARD AND DRIVERS LICENSE, WHICH WE WILL COPY FOR OUR FILES. THANK YOU. ******

EMERGENCY CONTACT NOT LIVING WITH YOU

NAME: _____ RELATIONSHIP: _____ PHONE # (____) _____

DUE TO OUR NOTICE OF OUR PRIVACY POLICIES YOU MAY REQUEST THAT WE COMMUNICATE CONFIDENTIAL HEALTH INFORMATION BY ALTERNATIVE MEANS. PLEASE INDICATE YOUR REQUEST BELOW AND ANSWER ALL THE QUESTIONS LISTED. IF IT DOES NOT APPLY PLEASE MARK THE (N/A) FIELD.

CONFIDENTIAL INFORMATION:

___ YES ___ NO ___ N/A CONTACT ME AT MY HOME

___ YES ___ NO ___ N/A LEAVE MESSAGE ON MY HOME ANSWERING MACHINE

___ YES ___ NO ___ N/A CALL ME ON MY CELL PHONE

___ YES ___ NO ___ N/A LEAVE MESSAGE ON MY CELL PHONE VOICE MAIL

___ YES ___ NO ___ N/A CONTACT ME AT MY WORK.

IF YES, OK TO LEAVE MESSAGE? ___ YES ___ NO

BEST WAY TO REACH YOU REGARDING YOUR CONFIDENTIAL INFORMATION? (____) EXT. _____

ASSIGNMENT OF BENEFITS:

I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO THE PHYSICIAN / PRACTICE SUBMITTING CLAIMS ON MY BEHALF.

X _____ DATE: _____

PRIVACY & RELEASE OF INFORMATION:

I HAVE BEEN NOTIFIED OF MY PRIVACY RIGHTS AND SECURITY OBLIGATIONS AND I, ACCORDINGLY, AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS.

X _____ DATE: _____

IN OFFICE USE ONLY

VERIFIED BY: _____ DATE: _____