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ASSOCIATES IN OBSTETRICS & GYNECOLOGY

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KEZIA HAGIWARA, FNP-C
APRIL DODDER, WHNP-BC

PATIENT INFORMATION

Patient's Full Legal Name: _____
Last First MI Maiden

D.O.B.: _____/_____/_____ Age: _____ Allergies: _____

Patient's Address: _____

_____ _____ _____
City State Zip

Phone (H) _____ (W) _____ (C)_____

Social Security No: _____

Patient's Employer: _____ Occupation: _____

Marital Status: M S D W Student: FT___PT___ School: _____

Referred By:_____ Primary Doctor:_____

Sex: _____ Race: _____ Ethnicity: _____ Preferred Language:_____

How did you hear about Associates in OB/GYN: _____

Spouse/Parent Name: _____ Social Security Number: _____

Employer:_____ Work Phone : _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone Number: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to Provider. I authorize the submission of claims without obtaining my signature on each claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this Provider and its employees, agents, and assignees to contact me via e-mail, text messaging and to my cellular devices using automated telephone dialing systems.

Date: _____/_____/_____ **Signature:** _____

Insurance Information

Primary Insurance: _____

Subscriber: _____ Birth Date: _____/_____/_____

Policy#: _____ Group#: _____

Secondary Insurance: _____

Subscriber: _____ Birth Date: _____/_____/_____

Policy#: _____ Group#: _____

Medicaid Number: _____ Colorado Access: _____ PCP: _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGES TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.