Please complete entire form

*Your physician @ Gynics?*___________________________ Date:____

Name:____ Social Security #_____________________________
Last First Maiden
Address:____ Age:______ DOB:_____/_________/___________
Street Apt#
____ Phone:_________________Cell:________________
City State Zip Code E-Mail:______________________________________

Employer:____ Occupation:__________________________________

Address: ____ Telephone:___________________Ext:__________

Referred by:____ Primary Care Physician: _______________________

Husband's name or
Closest Relative:____________________________________ Relationship:________________________________

Address:____ Occupation:_________________________________

Employer:____ Phone:______________________________________

Name of Close Friend
or Relative:____ Home Phone:__________________________________

Address:____ Work Phone:__________________________________

Name of Insurance Co.________________________________ Group #:____________________________________
Name of Primary
Insured____DOB:____/_____/____ID#__________________________

PAYMENT OR COPAYS ARE REQUIRED AT THE TIME SERVICES ARE PROVIDED. PPO or HMO participants are responsible for informing office staff of need for referrals. Unauthorized services will be the responsibility of the patient. TISSUE REPORTS AND SPECIAL LAB TESTS may be billed to you from the reference lab. Should your insurance carrier require you to use specific ancillary facilities (labs, x-ray, etc) inform your nurse. Failure to do so may result in charges to you that your insurance company may not cover.

INSURANCE: We file insurance claims for hospital related care and with contracted insurance carriers. A copy of your insurance card is required at the time of each visit. Any remaining balance after insurance payment is your responsibility. Follow up with your insurance carrier for reconsideration of your claim is your responsibility.

MATERNITY & SURGICAL SERVICES: Special financial arrangements are made in the business office. Applicable deductible/cost shares are to be paid prior to service. Pre-certification with your insurance company is your responsibility to obtain.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize GYNICS ASSOCIATES to furnish information to my insurance carriers concerning my illness and treatments and I hereby assign payment of benefits to GYNICS ASSOCIATES for medical services rendered:

Acknowledgement of Review of Notice of Privacy Practices as Posted

I have reviewed Gynics Associates Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____ ____
Signature of Patient or Personal Representative Name of Patient or Personal Representative

____ ____
Date Description of Personal Representative's Authority