

SHARP & STONE OB/GYN, PC
2700 10th Avenue South, Suite 306
Birmingham, AL 35205

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PATIENT INFORMATION	
Name _____	Soc. Sec. No. _____
Preferred Name _____	Date of Birth _____ Age _____ Race _____
Email Address _____	Referred to us by _____
Street Address _____	
City, State, Zip Code _____	
Home Phone (____) _____	Cell Phone (____) _____ Work Phone (____) _____
Patient's Employer (Indicate if Student) _____	
Employer's Street Address _____	
City, State, Zip Code _____	
Spouse's or Parent's Name _____	Spouse's SSN _____
Date of Birth _____	Home Phone (____) _____ Business Phone (____) _____
Spouse's or Parent's Employer _____	
PRIMARY INSURANCE INFORMATION	
Name of Primary Insurance Company _____	Contract Number _____
Group Number _____	Effective Date _____ Expiration Date _____
Policy Holder Name (If Different Than Above) _____	
Policy Holder's Relationship to Patient _____	Sex _____ Date of Birth _____
SECONDARY INSURANCE INFORMATION	
Name of Secondary Insurance Company _____	Contract Number _____
Group Number _____	Effective Date _____ Expiration Date _____
Policy Holder Name (If Different Than Above) _____	
Policy Holder's Relationship to Patient _____	Sex _____ Date of Birth _____
IN CASE OF EMERGENCY	
Name _____	Home Phone(____) _____ Business Phone (____) _____
Relationship to Patient _____	
EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES	
I hereby authorize Sharp & Stone OB/GYN, PC to release any and all information acquired in my examination, treatment and diagnosis to my insurance carriers and other treatment physicians. If I am covered by insurance, I will furnish my insurance card and signature.	
I hereby assign and authorize payment directly to Sharp & Stone OB/GYN, PC any medical and surgical benefits otherwise payable to me. Should an insurance payment be received that is less than the physician's usual charge for the services provided, I will be responsible for the difference. I understand if my insurance provider denies payment for any service for any reason I will be responsible for those charges.	
I also agree to pay all cost of collection including, but not limited to reasonable attorney's fee, and waiver all claims of exemption under the law of the state of Alabama. Form must be signed and dated by patient or responsible party.	
Date _____	X _____ Patient and/or Responsible Party

SHARP & STONE OB/GYN, P.Cc
Financial Responsibility Agreement

- ❖ **CO-PAYMENTS:** Co-payments are required at the time of service.
- ❖ **BALANCES:** Balances must be paid in full before seeing the physician.
- ❖ **FMLA/DISABILITY FORMS:** There is a minimal **\$5.00 fee** for form completion. This fee is not reimbursed by your insurance, and payment is required prior to completion. Once completed, it is our policy to not fax these forms. However, you may pick them up or we will be happy to mail them to you.
- ❖ **NON-COMPLIANCE IN KEEPING APPOINTMENTS:** There is a **\$25.00 fee** for appointments that are not kept.
- ❖ **ANNUAL EXAMS:** The annual/preventative medicine exam fee is covered by insurance. However, please note that lab work or other ancillary services associated with this visit may not be paid by your insurance and you will be asked to pay at the time of service.
- ❖ **OBSTETRICAL SERVICES:** Our staff will contact your insurance company to determine what they will pay towards your delivery. If your insurance will not pay for your obstetrical care/delivery in full, or if you do not have insurance, we will let you know the amount owed. We will work with you on payment arrangements; however, we require the amount be paid in full by your 24th week of pregnancy.
- ❖ **PAYMENT FOR SURGICAL SERVICES:** Our staff will contact your insurance company to determine what they will pay towards your surgical procedure. You will be responsible for any deductibles, co-payments, or remaining balance. Payment in full is required three days prior to your scheduled surgery date. If payment is made less than three days prior to surgery please be prepared to pay by cash or credit card.
- ❖ **REFERRALS:** If your insurance requires you to have a referral from a primary care physician, it must be obtained prior to seeing one of our physicians. It is the patient's responsibility to obtain the referral from the insurance company. If we have not received the referral, payment in full is required at the time of service or your appointment may need to be rescheduled.
- ❖ Because there are numerous insurance policy contracts, each one being different, it is our policy that the patient be knowledgeable of their contract and benefits with their insurance policy.
- ❖ Your physician may order blood work, pap smear, urine culture, etc. in order to diagnose your condition. Our practice utilizes outside laboratories and pathologists to process these specimens. We will forward your information, including insurance, so that a claim can be filed. However, please keep in mind that you may receive a bill from these providers for these services.

Due to the increase cost for billing, patient's failure to fulfill their financial obligations, and other changes in healthcare regulations, it is necessary for our office to implement the above policies. If you have any questions or concerns regarding these policies, you may contact our Practice Administrator.

I fully understand my financial responsibility for services rendered at Sharp & Stone OB/GYN, P.C. and understand that failure to comply with these policies will result in having to reschedule any appointments until I am able to fulfill my responsibility.

Signature of Patient, or Responsible Party

Date

Printed Name of Patient, or Responsible Party

**AUTHORIZATION FOR THE RELEASE
OF PATIENT INFORMATION**

Please understand that it may be necessary for us to release some or all of the information contained in your medical records to other physicians, nurses, and/or healthcare providers. At times, other providers assist us in assessing a patient's conditions. Screening for potential problems or providing consultation under certain circumstances. All healthcare providers are required by law to keep your information confidential.

Also due to the increased awareness of quality care it may be necessary to disclose information regarding your care to healthcare agencies, both private and governmental. Your insurance company and/or your self-insured employer are such agencies. Regarding the information going to your employer other than information needed to verify your insurance coverage; the data released will consist of statistical information only.

_____ **I do not wish to have test results or other medical information released to any person other than myself**

_____ **I do wish to have test results or other information released to the following person(s) (these individuals are people other than medical personnel)**

_____	Relationship _____
_____	Relationship _____
_____	Relationship _____
_____	Relationship _____

It is the responsibility of the patient to notify this office of any changes to the above information if changes do occur. The patient must fill out another Authorization form with this new information.

_____ **Patient Signature**

_____ **Date**

_____ **Printed Name**

_____ **Social Security Number**

_____ **Witness**