Today's Date _____

Patient Full Name as it appears on insurance card: _____

Date of Birth _____ **SSN** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Additional Phone _____ **Email** _____

Employer _____ **Job/Dept** _____

Spouse Full Name _____ **Date of Birth** _____

Spouse SSN _____ **Phone #** _____

Spouse Employer _____ **Phone #** _____

Emergency Contact (Friend/Relative) _____

Emergency Contact Primary Phone _____ **Alternate** _____

Primary Insurance _____ **Insured Name** _____

Insured SSN _____ **Insured DOB** _____ **Relationship** _____

Policy/ID # _____ **Group#** _____

Secondary Insurance _____ **Insured Name** _____

Insured SSN _____ **Insured DOB** _____ **Relationship** _____

Policy/ID # _____ **Group#** _____

If MINOR, Need Responsible Party's Name _____

Relationship _____ **DOB** _____ **SSN** _____

Responsible Party's Phone# _____ **Alternate#** _____

Referred by _____ **Phone#** _____

PLEASE PROVIDE INSURANCE CARDS AND DRIVER'S LICENSE TO BE COPIED.

EVERYTHING MUST BE COMPLETED IN FULL BEFORE BEING SEEN!!!!

LABORATORY CONSENT

For your convenience, we have "in house" laboratory services provided by GenPath. GenPath is considered In-Network with most insurance companies. Memorial Health (Coresource), United Healthcare, Aetna, Cigna, Anthem BCBS, BCBS GA (non PPO), Medicare, Medicaid and Tricare are some of the Network plans. For a complete list, see the receptionist. GenPath accepts and bills all insurance plans, even if they are not in-Network. Patients will only be held financially responsible for unmet copays, coinsurance, and deductibles.

If you prefer we utilize another laboratory provider, you must notify us prior to any labs or test being done here on this form and in the lab area.

_____ I will use GenPath laboratory

_____ Preferred lab _____

Patient Signature _____ Date _____

WAIVER FOR PATIENT LIABILITY FOR NON-COVERED TEST AND SURGICAL PROCEDURES

Dear Patient:

There have been many changes to insurance coverage. Your Physician may order a test that your insurance doesn't cover. Our Physicians are committed to providing the very best health care and do not know if your insurance plan will cover all tests, such as Hemoglobin, Urinalysis, Hemocult (test blood in stool). Please understand that you will be responsible for tests and/or procedures not covered by your plan.

By signing I agree to be fully responsible if not covered by insurance.

Signature _____ Date _____

ADVANCED BENEFICIARY NOTICE FOR MEDICARE (ABN)

Medicare patient please initial below

_____ Medicare does not usually pay for a urinalysis without symptoms of a urinary problem.

_____ Medicare does not usually pay for hemoglobin without symptoms of anemia.

_____ Medicare only pays for a screening pelvic exam and pap every two years.

_____ Medicare does not cover finger stick cholesterol, the test must be a blood draw.

I have been notified by my Physician that he or she believes that, in my case, Medicare will likely deny payment for the service listed above. If Medicare denies payment I agree to be personally responsible.

Acknowledgement of receipt of Privacy Notice

I have been presented with a copy of Savannah OB/GYN PC's privacy policies detailing how my PHI may be used and disclosed as permitted under federal and state law. Your medical information will not be shared with even a family member. I understand the contents of the Notice and I request only the following individuals have access to my personal medical (including billing) information:

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of previous and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignments of benefits apply.

Print patients name: _____ DOB _____

Signature: _____ Date _____

If not signed by patient, please indicate relationship to patient

Relationship: _____ Witnessed by: _____

Internal use only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title) _____

SAVANNAH OB/GYN, PC
HEART & LUNG BLG
5356 REYNOLDS ST., SUITE 410
SAVANNAH, GA 31405
(912)355-8136 (912)352-7014

Alan E. Smith, M.D., F.A.C.O.G.
Amy C. Burgett, M.D., F.A.C.O.G.
Melanie Howard, RN MSN FNP
Leah Marks, RN BSN FNP

In order to save money on mail and save some trees from being made into pink and yellow cards, we are offering an email option. Please indicate below if we can contact you by email with lab results and other information:

_____ Yes please save the trees.

_____ No thank you, I prefer a card in the mail.

If you answered yes please put your full name and email address on the pink card.