Gynemedic

Important
All payments including co-pays and co-insurance are due at the time of service. Please arrange to have authorization done before your appointment if you insurance plan requires pre-authorization for our services.

Last Name: _____First Name:_____MI: _____
Telephone home:_____ Cell Phone:_____

May we leave a message with test results on your voice mail ☐yes ☐no

Date of Birth: _____Age: _____Martial Status:_____SSN#: _____

Address:_____City:_____State:_____Zip Code :_____

Email Address: _____
How were you referred to our practice:_____

Employer:_____Occupation:_____Phone:_____

Federal Privacy Standards require the following information:
Ethnicity: _____Race: _____Preferred Language:_____

Spouse/Parent Name:_____Date of Birth:_____Phone:_____
Employer:_____Occupation:_____Phone:_____

Emergency Contact:_____Relationship:_____Phone:_____

Primary Insurance Company_____Name of insured_____
Date of Birth:_____SSN#:_____Employer:_____
Insurance address: _____Policy#_____Group#_____
Secondary Insurance Company_____Name of insured_____
Date of Birth:_____SSN#:_____Employer:_____
Insurance address: _____Policy#_____Group#_____

Please Read:
Release of information regarding TEST/PROCEDURE RESULTS:
Who may receive information regarding your Protected Health Information?
Name:_____Relationship_____Date of Birth_____
Name:_____Relationship_____Date of Birth_____

All charges are due at the time of service. If surgery is indicated, payment arrangements may be made and the patient is responsible for furnishing insurance forms to the office prior to surgery. **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment directly to Gynemedic/Dr Armity Simon for the surgical and/or medical service. I understand that I am financially responsible for all charges, regardless of insurance coverage. I also authorize the release of necessary medical information to the insurance company to assist in processing my medical claims.
If not covered by insurance, how do you plan to pay for this visit? ☐ Cash ☐ Check ☐ Visa ☐ Mastercard
CONSENT TO TREAT:
I _____,HEREBY CONSENT TO RECEIVE MEDICAL CARE TO BE ADMINISTERED BY GYNEMEDIC/ARMITY A SIMON. MD. A PHOTOCOPY OF THIS SIGNATURE IS ACCEPTABLE AS THE ORIGINAL

_____
Signature Date