NORTHERN INDIANA CENTER FOR PELVIC HEALTH & GYNECOLOGY
707 N. MICHIGAN STREET, SUITE 102 SOUTH BEND, IN 46601

PATIENT INFORMATION Preferred Pharmacy: _____

Last Name_____ First Name_____ MI _____ Sex: ☐ Male ☐ Female

Social Security # _____ Date of Birth_____ Marital Status: ☐ Married ☐ Single ☐ Other

Address_____City_____State_____ Zip_____

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Other_____ Religion: _____

Language: ☐ English ☐ Spanish ☐ Other _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Home Phone (___) _____ Cell (___) _____ Work (___) _____ ☐ Student ☐ Retired ☐ Employed

E-Mail Address_____

Patient's Employer_____ Employer's Address_____

Primary Care Physician: _____ Phone Number: _____

Emergency Contact_____ Phone (____) _____ Relationship_____

GUARANTOR (RESPONSIBLE PARTY) INFORMATION

Last Name_____ First Name_____ MI_____

Address_____ City_____ State_____ Zip Code_____

Relationship to Patient_____ Sex: ☐ M ☐ F Employer: _____

Date of Birth_____ Social Security #_____

Home Phone (___) _____ Cell (___)_____ Work (___)_____

PLEASE ALLOW US TO PHOTCOPY YOUR INSURANCE CARD(S)
PLEASE FILL OUT BELOW IF CARD HOLDER IS DIFFERENT THAN GUARANTOR

PRIMARY INSURANCE INFORMATION

Insurance Company Name_____

Name of Insured _____ Sex: ☐ M ☐ F Date of Birth_____

Address _____City_____State_____Zip_____

Insured's Social Security Number: _____

Is this an Employer's Plan? ☐ Yes ☐ No If so, Insured's Employer: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name_____

Name of Insured _____ Sex: ☐ M ☐ F Date of Birth_____

Address _____City_____State_____Zip_____

Insured's Social Security Number: _____

Is this an Employer's Plan? ☐ Yes ☐ No If so, Insured's Employer: _____

Consent for Treatment and Authorization for Release of Information

I hereby consent to and authorize Northern Indiana Center for Pelvic Health & Gynecology to provide and perform such medical care, tests, procedures, drugs and other services and supplies as are considered advisable by such health care providers for my health and wellbeing. If I should not comply with the medical program of care provided or recommended by physician or designated alternate(s), I understand that I then relieve my physician, designated alternate(s), associated medical staff and Northern Indiana Center for Pelvic Health & Gynecology of all responsibility resulting from my action.

I also authorize Northern Indiana Center for Pelvic Health & Gynecology to gather, maintain and release any and all information that may be required for the processing of any and all claims for third party payers (including but not exclusive of, private insurance, Medicaid, Medicare, Tricare, Disability, etc.).

_____ I acknowledge that I have been given the ability to review Northern Indiana Center for Pelvic Health & Gynecology's Notice of Initial Privacy Practices.

Patient's Signature_____Date_____ Time_____ AM/PM

Other Authorized Person_____ Relationship to Patient_____

Witness: _____

NOTICE TO OUR PATIENTS

IN ORDER FOR US TO REMAIN HIPAA COMPLIANT, PLEASE LIST ANY PERSON(S) OR COMPANIES THAT YOU GIVE YOUR PERMISSION TO OBTAIN WRITTEN OR VERBAL INFORMATION ON YOUR BEHALF: (YOU DO NOT HAVE TO LIST YOURSELF OR OTHER PHYSICIANS)

Name	Relationship	Phone Number
Name	Relationship	Phone Number

May we leave detailed messages, which may include but are not limited to, information about prescriptions or test results on your answering machine? ☐ Yes ☐ No

May we leave detailed messages which may include but are not limited to, information about prescriptions or test results with a member of your household? ☐ Yes ☐ No

Signature _____ Date _____

MEDICARE AUTHORIZATION

I am giving Northern Indiana Center for Pelvic Health & Gynecology permission to ask for Medicare payments for my medical care. I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests. I understand that the Center for Medicare and Medicaid Services (CMS) is the government Medicare agency.

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by Northern Indiana Center for Pelvic Health & Gynecology. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

Signature _____ Date _____

MEDIGAP AUTHORIZATION

I request that payment of authorized MediGap benefits be made either to me or on my behalf to the physician of Northern Indiana Center for Pelvic Health & Gynecology for any service furnished me by that physician. I authorize any holder of medical information about me to release to _____(Medigap insurer) any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____