Renaissance OBGYN of Cortland, PLLC

Personal Information

(Please fill in all that apply)

Patient Name_____Maiden_____

Date of Birth____/____/____ Social Security Number ____-____-____

Mailing address_____

City_____ State_____ Zip Code_____

Home Phone_____Ok to leave message? Y / N Brief **OR** Detailed

Cell Phone_____Ok to leave message? Y / N Brief **OR** Detailed

Work Phone_____ Ok to leave message? Y / N Brief **OR** Detailed

Marital Status: Married__ Single__ Partner__ Divorced__ Legally Separated __ Widowed__

Race: Asian__ Hawaiian/Pacific Islander__ African American__ White__ Hispanic__ Other__

Ethnicity: Hispanic__ Non Hispanic__ **Language**_____

Would you like to be web enabled to use our patient portal to view test results, appointments, billing, and contact our office by email? Y / N

If yes, what is your email address _____

Primary Care Physician_____

Address_____

Phone Number_____

Referring Physican_____

Address_____ Phone Number_____

Pharmacy Name_____

Address_____

Phone_____ Fax_____

Renaissance OBGYN of Cortland, PLLC

Employer Information

(Please check all that apply)

Not Employed ___ Employed ___ Student ___ Student and Employed ___

Employer _____

Phone _____ Ext. _____

Spouse/Partners Name _____

Spouse/Partners Employer _____

Phone _____ Ext. _____

Emergency Contact Information

Name _____ Relationship _____

Address _____

Phone _____

Insurance Holder Information

Name of person who holds the insurance policy (if not self)_____

Relationship to patient _____ Date of Birth ___/___/___ Male ___ Female ___

Address _____

Phone Number _____

Renaissance OBGYN of Cortland, PLLC

Patient Record of Disclosures

Person with whom we may disclose health Care Information to, if any (ie: PCP, spouse, parent/guardian) _____

Relationship to patient_____

Limitations (if any) _____

OR

____ I do not wish to disclose my health care information to anyone at this time.

Signature_____ Date _____

For Minors under 18 years

Mother/Legal Guardians Name _____

Date of Birth ____/____/____ Social Security Number _____-_____-_____

Address (if different than patient) _____

Home Phone_____ Cell Phone_____

Employer_____

Father/Legal Guardians Name_____

Date of Birth ____/____/____ Social Security Number _____-_____-_____

Address (if different than patient) _____

Home Phone_____ Cell phone _____

Renaissance OBGYN of Cortland, PLLC

Patient HIPAA Awareness

(Health Insurance Portability and Accountability Act)

Please read the following information and sign and date the bottom.

With my permission, Renaissance OBGYN of Cortland may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Renaissance OBGYN of Cortland Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Renaissance OBGYN of Cortland reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Renaissance OBGYN of Cortland may mail to my home, or another designated location, and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my permission, the office of Renaissance OBGYN of Cortland may mail to my home, or another designated location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal or Confidential.

With my permission, the office of Renaissance OBGYN of Cortland may mail to my home, or another designated location, any items that assist the practice to carry out TPO, such as appointment reminder cards and patient statements. I have the right to request that Renaissance OBGYN of Cortland restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Renaissance OBGYN of Cortland to use and disclose my PHI and TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient (or legal guardian) _____

Print name of patient (or legal guardian) _____

Renaissance OBGYN of Cortland, PLLC

Financial Policy

Renaissance OBGYN Providers and staff are dedicated to providing the best possible care for you. We value the trust and responsibility you place in us to provide you with the best quality of care. We want to ensure that our financial policies are clearly presented and understood by you. If you have any questions regarding our financial policies, please contact our billing office at 607-758-9977.

- Patient responsibility: It is your responsibility to know your insurance benefits and confirming our participation with your plan. You must present your insurance card(s) at each visit. Failure to provide valid insurance information to us prior to your visit may result in payment in full at the time of service or in the event the insurance is denied due to inaccurate information that was provided.
- Appointments: If you need to cancel or reschedule your appt appointment, we ask you to give us 24 hours notice. If you fail to give us notice, we will charge you a $25.00 charge for an office visit, a $50.00 charge for an ultrasound, or a $75.00 charge for a procedure. Excessive abuse of the scheduled appointments (no shows, chronic lateness, etc) may result in discharge from the practice.
- Co pays, coinsurance, and deductibles: As part of your contract with your insurance company, all co-payments are required at time of service. In addition, you are responsible for all coinsurance and deductibles. Any balance that is over 30 days will have a 15% interest added. For your convenience we do accept cash, personal checks, and credit cards. All returned checks will be charged a $25.00 processing fee.
- Collections: Patients who do not make responsible progress toward resolving outstanding debt to the practice may be turned over to our collection agency. If this occurs you will be responsible for the outstanding balance due to our practice and a fee charged to your account for collection agency processing. In addition you may be responsible for any attorney fees in addition to the balance.
- Miscellaneous forms: Any patient who requests copies of their records will be charged $0.75 per page. This will help offset the administrative expenses incurred by our office.

It is important that you understand the Financial Policy. Please feel free to contact us with any questions prior to your appointment.

I have read and understand the practice's Financial Policy and I agree to be bound by its terms. I also understand that such terms may be amended by the practice from time to time.

Patient Signature _____ ***Date*** _____