

(847) 259-4122 • [www.ObGyneAssociates.com](http://www.ObGyneAssociates.com)

121 South Wilke Road, Suite 311 • Arlington Heights, IL 60005

Fax: (847) 259-7571

*Ob-Gyne Associates, SC*

The options, expertise & personal care you deserve



Acct. # \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE PRINT:**

**Patient's: Last Name                      First Name                      Middle Name                      Maiden Name**

**Home Address: Street                      Apt #                      City                      State                      Zip**

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_    **Social Security Number:** \_\_\_\_-\_\_\_\_-\_\_\_\_    **Marital Status:** \_\_\_\_

(\_\_\_\_)\_\_\_\_-\_\_\_\_    (\_\_\_\_)\_\_\_\_-\_\_\_\_    (\_\_\_\_)\_\_\_\_-\_\_\_\_    (\_\_\_\_)\_\_\_\_-\_\_\_\_

**Home Phone Number                      Work Phone Number                      Cell Phone Number                      Pager Number**

**Pharmacy of preference :** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_ @ \_\_\_\_\_

**Emergency Contact: Name** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Patient Employer Name:** \_\_\_\_\_

**Spouse/Parent Name:** \_\_\_\_\_ **Spouse/Parent SS#:** \_\_\_\_-\_\_\_\_-\_\_\_\_

**Spouse's Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

I, the above patient hereby certify that I am eligible for the health plan coverage with my/my spouse's insurance plan. I hereby certify that I am fully aware of the following conditions for my insurance and regarding payment.

**Full payment, co-insurance, or co-payments are due at the time of service.**

Our office will bill your insurance company. You must pay any co-payments at the time of service.

I understand that I may have requested medical care that may not be covered by the insurance plan or may be considered medically un-necessary for services rendered.

I understand that if I do not have coverage or I am not eligible under the terms of the subscriber insurance agreement, I am liable for all charges for services rendered and agree to pay in full today.

I understand that if I receive services without proper authorization from my Primary Care Physician, I am liable for payment in full today.

I understand that if I give incorrect insurance information, I must pay the bill in full within 30 days.

I understand that if my insurance card has not been issued at the time of service, I must pay for the bill in full at the time of the visit.

I understand that if for any reason my account goes to a collection agency, you can and will collect the collection fee in addition to my unpaid balance.

By updating the above information each visit, I agree to the above terms.

Signature \_\_\_\_\_