NAME (PLEASE PRINT) DATE ______

FIRST	M.I.	LAST	NAME YOU GO BY

MARITAL STATUS	DATE OF BIRTH	AGE	SOCIAL SEC. NO.	CELL #

STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO.
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED	WORK PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE		ZIP CODE
E-MAIL ADDRESS			

* PLEASE SIGN BELOW IF YOU DO NOT HAVE AN EMAIL ADDRESS OR IF YOU REFUSE TO GIVE US YOUR EMAIL INFORMATION.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE:

IN CASE OF AN EMERGENCY WHOM MAY WE CONTACT?	PHONE NO.
NEAREST FRIEND NOT LIVING WITH YOU	PHONE NO.
LANDLORD	PHONE NO.

HUSBAND'S NAME	PARENT'S NAME, IF MINOR		
HUSBAND'S OR PARENT'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	WORK PHONE NO.
ADDRESS OF HUSBAND OR PARENT'S EMPLOYER	CITY AND STATE		ZIP CODE
NEAREST RELATIVE NOT LIVING WITH YOU	ADDRESS		PHONE NO.

CONSENT FOR TREATMENT - RELEASE OF MEDICAL INFORMATION - FINANCIAL RESPONSIBILITY

I, the undersigned, consent to treatment necessary for the care of the above named patient. I hereby authorize release of any or all medical records to referring physicians, my insurance carriers, or those involved in payment of my account. I give OB/GYN Associates, P.A. its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call, text message,or e-mail), for the purpose of treatment, insurance, unpaid balances, and/or payment.

I further acknowledge full financial responsibility for any services rendered by OB/GYN Associates, P.A. and understand that payment of charges incurred in the office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to OB/GYN Associates, P.A. In the event an account is not paid within 90 days, the undersigned agrees to pay all costs of collection including attorneys fees and court costs (33%) and hereby waives all right of exemption under the constitution of the State of Alabama.

Your physician is here to provide you with the best care possible. If services, that your physician feels necessary for the treatment of your condition and maintenance of good health are NOT covered by your insurance health benefits contract, you are expected to pay for those services in full. If you have any questions about whether or not a particular service is covered by your health benefits contract, someone in our office will be happy to assist you.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the physician's office. Please sign below that you have read and agree to this financial policy.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE:

SIGNATURE OF CO-RESPONSIBLE PARTY DATE: