SPARTANBURG & PELHAM OB-GYN, P.A.

Hoang N. Giep, M.D.
Ashley R. Fowler, M.D.
Jennifer F. Allen, M.D.
Amanda T. Abraira, M.D.
Lindsay E. Young, M.D.
Amber Bartkowiak, FNP-C

NAME: _____ **PREFERRED NAME:** _____
LAST **FIRST** **MIDDLE INITIAL**
DOB: _____ **S.S.N:** _____ **EMAIL:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:**_____

HOME PHONE:_____**CELL PHONE:** _____ **WORK PHONE:**_____

MARITAL STATUS:_____**LANGUAGE:**_____**RACE/ETHNICITY:** _____

EMPLOYER:_____**OCCUPATION:** _____

PRIMARY CARE PHYSICIAN: _____**PHONE #:**_____

EMERGENCY NOTIFICATION INFORMATION:
NAME: _____**RELATIONSHIP:**_____**PHONE #:**_____

PREFERRED PHARMACY NAME: _____**PHONE#:**_____
ADDRESS: _____

PRIMARY INSURANCE: _____ POLICY HOLDER'S NAME: _____

POLICY #:_____ GROUP #:_____RELATIONSHIP:_____

POLICY HOLDER'S SSN: _____ POLICY HOLDER'S DOB:_____

SECONDARY INSURANCE: _____ POLICY HOLDER'S NAME: _____

POLICY #:_____ GROUP #:_____RELATIONSHIP:_____

POLICY HOLDER'S SSN: _____ POLICY HOLDER'S DOB:_____

I am the patient or responsible party for above-mentioned patient. The personal and health insurance information above is true and accurate to the best of my knowledge. I understand that my health insurance plan(s) may not pay for services I receive from Spartanburg & Pelham, OB-GYN if I present with inaccurate, invalid, or incomplete personal and/or health insurance information.

I understand that I am responsible for notifying Spartanburg & Pelham, OB-GYN of any changes in my personal and health insurance information. I have informed Spartanburg & Pelham, OB-GYN of ALL insurance plans for which I am eligible and/or a beneficiary. If my health insurance carrier(s) deny payment for any/all services I receive from Spartanburg & Pelham, OB-GYN because I did not provide accurate, valid, or complete personal and/or health insurance information, I understand that I will be financially responsible for any/all charges due.

PRINT NAME: _____ RELATIONSHIP TO PATIENT IF RESPONSIBLE PARTY: _____

PATIENT OR RESPONSIBLE PARTY'S SIGNATURE: _____DATE:_____

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HIPPA NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

I, _____(please print patient name) have been provided access to a copy of Spartanburg & Pelham, OB-GYN's NPP for review.

This acknowledgement form will be in effect until otherwise revoked by me in writing. I understand that I may ask questions to the Privacy Officer if I do not understand any information contained in the Notice of Privacy Practices.

I hereby authorize and consent to all examination and treatment necessary for the care for the patient named above. I consent to all procedures incident to such treatment which are deemed necessary by the provider. I authorize the release of medical information to process my claims and authorize Spartanburg & Pelham, OB-GYN direct receipt of insurance payment for services rendered.

I herby consent to the release of any/all information regarding my medical history, current medical condition, current medical treatment, and any/all patient account information to the individual(s) listed below: (if you do NOT want any information to be released, please leave access to medical information blank).

Access to Medical Information

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

PATIENT PORTAL

We are excited to invite you to join our patient portal. The portal will allow you to communicate with your provider, view upcoming appointments and view your health information including, but not limited to lab results. **Register Email:** _____

_____ _____
Patient Signature **Date**

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FINANCIAL POLICY

Thank you for choosing Spartanburg & Pelham, OB-GYN as your health care provider. We are committed to your health and well-being and want your care and treatment to be successful. Please understand that payment of your account is considered an integral part of your treatment.

We ask that all responsible parties read and sign this policy prior to seeing the physician. This policy is offered to develop and sustain a continued professional and pleasant relationship. Our billing department will be available to discuss our fees and this policy with you.

We are a specialist healthcare provider, therefore specialist co-payments & deductibles are due at the time of service.

Our providers accept MOST (but not all) insurance plans**. (Please check with our staff if you are unsure if we accept your plan)**. If your insurance plan is one which we do not accept you may be seen and treated by providers at Spartanburg & Pelham, OB-GYN as out-of-network. You may be responsible for full charges of services rendered or must pay out-of-network cost-sharing under your health plan. **(Please see OON consent and estimated cost of services)**

Uninsured (SELF-PAY): Payment in **FULL** is expected at the time of service unless arrangements have been made with our billing department prior to services being rendered.

We accept **Cash, Check, AmEx, Visa, Mastercard, Discover, Apple pay (on-site only), and Care Credit.**

PLEASE CAREFULLY READ THE FOLLOWING:

1. We will ask for your insurance card at **EVERY VISIT**. Please be prepared to present it at check-in.
2. Payments for all services, which include unpaid balances, deductibles, co-payments, or other non-covered services as set by your insurance carrier are due at the time of service. Unpaid balances may be subject to collection placement and collection fees. **A $35 service fee will be assessed for Returned Checks, regardless of the reason.**
3. Your insurance policy is a predetermined agreement between you, your employer, and the insurance company. We are **NOT** a party to that agreement. Our relationship is with **YOU**, not your insurance company. As your provider we will provide factual information to facilitate claim processing. Please understand that we may not know whether your insurance will cover your service(s) until the claim has been submitted. As well as we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Any laboratory test which requires an outside lab to perform will be billed by that company.
4. I understand and agree if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Spartanburg & Pelham, OB-GYN, I will be responsible for all cost of collecting monies owed, including court cost, collection agency fees and attorney fees.
5. **A $25 charge** will be accessed to your account for failure to notify the office **24 HOURS** prior to your scheduled appointment time. When an appointment is scheduled with a provider, time is specifically allocated for you. Failure to no-show 3 times in a calendar year will prevent us from rescheduling any appointments for you.

FINANCIAL AGREEMENT

I have read, understand, and agree to this financial policy. In the event of non-payment by my insurance carrier for whatever reason, I understand that I am responsible for payment of the balance owed, inclusive of all court cost and attorney fees of 30%. I authorize the release of any medical or other information necessary to process medical claims. I authorize payment of medical benefits to Spartanburg & Pelham, OB-GYN.

_____ _____

Patient Print Name Date

_____ _____ _____

Signature of Patient and/or Guardian Relationship to Patient Witness (Staff)