MATERNAL GYNERATIONS

600 Professional Dr., Suite 200, Lawrenceville, GA 30046
2098 Teron Trace, Suite 150, Dacula, GA 30019
Call 770.513.4000 | Fax 770.237.2523
MaternalGynerations.net

PATIENT ACCOUNT # _____ Referred by: _____

Preferred Pharmacy, Address, Phone Number & City_____
By providing a pharmacy, I give permission to send and receive prescription information between Maternal Gynerations, PC and my pharmacy

Your Name: _____
Last First Middle
Preferred Name: _____ Primary Language: _____

Date of Birth: _____ SSN: _____

Race: □ American Ind. /Alaska Native □ Asian □ Black/African American □ Nat Hawaiian/Pacific Islander □ White □ Other Race □ Decline
Ethnicity: (MUST COMPLETE) □ Hispanic or Latino □ Not Hispanic or Latino □ Declined Marital Status: S M D W

Address: _____Apt # _____

City: _____ State: _____ Zip Code: _____

Home # _____Work# _____Cell # _____

Email: _____ Employer: _____

Preferred Communication for Appointment Reminders: □ Email □ Phone □ Text

Emergency Contact: _____Relationship: _____ Phone Number: _____

Is your insurance through (please circle all that apply): My Employer Private Spouse Parent

Insurance Co. Name: _____

Full Name of Insured: _____

Date of Birth: _____Social Security Number: _____

It is the policy of this office to pay for services in full when rendered except in cases of pregnancy or surgery. If this applies to you, we will file your claim and you will be expected to pay only what the insurance does not pay. You must have your current insurance card at time of service or you will be expected to pay in full. Return check fee is $30. A no show fee of $25-50 will be billed if appointment is not cancelled within 24 hours. Insurance is not a guarantee of payment. It is your responsibility to confirm your benefits.

In case any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein incurred. If this account is placed with a collection agency, the undersigned parties agree to pay all fees for cost of collections.

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information for the processing of this claim. I understand that my prescription will be sent, and my medication information, including formulary benefits, may be obtained through MatGyn electronic prescribing function.

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____

HIPAA PRIVACY RULE: Please list the parties that you authorize Maternal Gynerations, P.C. to disclose your protected health information (PHI). **MUST BE FILLED OUT BY PATIENT ONLY** (If this form is completed electronically via the Patient Portal, then you will be asked to initial this HIPPA Authorization when you come in to the office.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

DO YOU GIVE MATERNAL GYNERATIONS P.C. PERMISSION TO LEAVE VOICEMAILS REGARDING TEST RESULTS? □ Yes □ No
PATIENT'S INITIALS _____

I HAVE RECEIVED/READ A COPY OF MATERNAL GYNERATIONS. P.C. NOTICE OF PRIVACY PRACTICES. PATIENT'S INITIALS _____