Patient Registration
Registracion del Paciente

Date: _____

Patient Information/*Informacion del Paciente*:

Social Security#: _____
Numero de Seguro Social

First Name: _____
Primer Nombre

Last Name: _____
Apellido

Date of Birth: _____/_____/_____
Fecha de nacimiento

Race/Ethnicity: _____
Nacionalidad

Marital Status: _____
Estado Civil

Employer: _____
Empleador

Email Address/***Direccion Electronica***
_____

Home Address/ *Direccion De Hogar*:
_____
City: _____ State: _____ Zip: _____
Cuidad ***Estado*** ***Codigo Postal***

Home Phone: (_____) _____
Telefono del Hogar

Cellular Phone: (_____) _____
Telefono de Celular

Work Phone: (_____) _____
Telefono del Trabajo

Allergies to Meds/ *Allergias a Medicinas*:

Pharmacy Name & Phone / *Farmacia*:

Referred By/ *Referido Por:*

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST- POR FAVOR ENTREGUE SU TARJETA DE SEGURO A LA RECEPCIONISTA.

Insurance Information / Informacion de Seguro:
____ Commercial ____ Medicare ____ Other _____

Insurance Company: _____
Compania de Seguro

Insured/Card Holder's Name:_____
Nombre del Asegurado

Relationship: _____
Relacion

Policy#: _____
Numero de Poliza

Insurance Phone #: (____) _____

Group#: _____

Primary Insurance Holder / *Primario de Seguro:*

Social Security#: _____
Numero de Seguro Social

Date of Birth: _____/_____/_____
Fecha de Nacimiento

Relationship: _____
Relacion

Daytime Phone: (_____) _____
Telefono durante el dia

First Name: _____
Primer Nombre

Employer: _____
Empleo

Last Name: _____
Apellido

Address: _____
Direccion
City: _____State: _____Zip:_____

Emergency Contact / *Contact de Emergencias,*

First Name: _____
Primer Nombre

Home Phone: (_____) _____
Telefono del Hogar

Last Name: _____
Apellido

Work Phone: (_____) _____
Telefono del Trabajo

Relationship to patient: _____
Relacion al paciente

Cellular Phone: (_____)_____
Telefono de celular

SOUTH MIAMI
OB-GYN
ASSOCIATES

Your healthcare provider may perform a routine test in conjunction with your Pap Smear to screen for the presence of HPV (Human Papilloma Virus). Approximately 80% of women are exposed to this virus at some point in their lives and screening is recommended to assist in the detection and prevention of cervical cancer.

Your insurance may or may not cover this additional screening test. If the test is not covered by your insurance provider, the additional out of pocket cost is approximately $100.00.

_____ I choose to include HPV screening with Pap Smear.

_____ I choose to decline HPV screening with Pap Smear.

_____
Patient Name (Please print)

_____ _____
Signature Date

7300 S.W. 62nd Place ♦ 3rd Floor ♦ South Miami, Florida 33143
Tel: (305) 665-1133 ♦ Fax: (305) 666-0258
www.southmiamiobgyn.com

SOUTH MIAMI
OB-GYN
ASSOCIATES

Patient Financial Agreement

PLEASE READ THOROUGHLY AND SIGN BELOW

Upon receiving services from South Miami OB/GYN Associates, you agree:
In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our billing department. We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract.
- We will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable length of time (within 90 days), you may be responsible.
- All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**
- Upon check-out, we will collect your deductible, co-pay, and payment for any uncovered services as well as the patient's portion as determined by insurance. We accept cash, check, and credit card of Master Card, Visa, Discover, American Express, and Care Credit.
- If your account is more than 90 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, it may be sent to a collection agency. If an account is sent to collections, it is the policy of this office to refrain from providing further medical care until the balance is paid in full.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.

X _____ Date_____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY

X _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

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