## 

## PLEASE PRINT CLEARLY Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Patient’s Legal Name:Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.I.\_\_\_\_\_

# Address: Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Unit#\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_\_\_

# Home Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Cell Phone(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_MaritalStatus\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Race\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Employer Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Who referred you to our office\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Emergency Contact

# Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### GUARANTOR/SPOUSE/ PARENT INFORMATION

## Guarantor/Spouse Legal Name:Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.I.\_\_\_\_\_\_\_

# Address:Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Unit# \_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

# SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Relationship to Guarantor: Spouse\_\_\_\_ Child \_\_\_\_ Legal Guardian\_\_\_\_\_ Other\_\_\_\_\_\_\_\_

# INSURANCE INFORMATION

# Primary Insurance Company and Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Insurance Group Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Insured’s SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have secondary insurance: Yes No Is this a Medicare supplementary policy?\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company and Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Group Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Insured’s SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREFERRED PHARMACY/FARMACIA DE PREFERRECIA**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Address and/or X Streets City Sate Zip Code**

## CONSENT TO CONTACT

If Delaware Center of Excellence in Obstetrics and Gynecology, P.A. needs to contact me regarding any future appointments or give test results they may leave a message. Yes or No

I give Delaware Center of Excellence in Obstetrics and Gynecology, P.A permission to leave all X-ray, lab results, test results, and other medical information and advice on: (check all that apply) \_\_\_\_Voice mail at work \_\_\_\_\_\_Answering machine at home/cell phone\_\_\_\_\_Other \_\_\_\_\_ Do not leave a message

I further consent for Delaware Center of Excellence in Obstetrics and Gynecology, P.A to provide communications and/or lab results through my e-mail\_\_\_\_\_\_\_\_\_\_\_\_\_(initial)

INITIAL:\_\_\_\_\_\_\_\_\_\_

## CONSENT FOR TREATMENT

I, the undersigned, voluntarily agree to tests, procedures, and/or treatments, which the attending physcian or healthcare professional and I have discussed and deemed necessary and which is administered to be performed on me under the direction of the physcian or healthcare professional or his/her designee.

INITIAL:\_\_\_\_\_\_\_\_\_\_

PAYMENT TERMS AND AGREEMENTS

I, the undersigned, in consideration for services rendered to the patient by Delaware Center of Excellence in Obstetrics and gynecology, P.A., understand and agree to the following:

1. I understand that payment for charges is due on the date of service with the exception of insurance carriers for which Delaware Center of Excellence in Obstetrics and Gynecology, P.A. is under contract to file directly.
2. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment from Delaware Center of Excellence in Obstetrics and Gynecology, P.A.. I will be responsible for any co-payment, deductible or service not covered by my insurance provider. If I do not have insurance coverage for services rendered by Delaware Center of Excellence in Obstetrics and Gynecology, P.A., I agree to pay all charges resulting in such services.
3. I hereby authorize Delaware Center of Excellence in Obstetrics and gynecology, P.A.to file with my insurance carrier and I assign payment of medical benefits to Delaware Center of Excellence in Obstetrics and Gynecology, P.A..
4. I authorize release of any and all medical records and information necessary to process any claim generated by services I received in this office.
5. I will keep my account current as to charges for which I am responsible. In the event that I fail to pay charges, Delaware Center of Excellence in Obstetrics and Gynecology, P.A. is entitled to take whatever action necessary to collect such charges and I will be responsible for reasonable attorney’s fees and costs incurred as a result of such collection.

**NOTICE**: Your records will only be stored for seven years ***following your last visit in our office***, then destroyed according to our office policy.

# INITIAL:\_\_\_\_\_\_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

I, the undersigned, have read the Notice of Privacy Practices and fully understand my rights and how my medical information may be used and disclosed and how I can get access to this information.

**INITIAL:\_\_\_\_\_\_\_\_\_\_**

***My signature below indicates that I have read, understand and agree to all terms set above:***

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please bring this information sheet with you when you arrive for your appointment.*



**AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS / VIDEOS**

Obstetrics and Gynecology is a field of medicine that treats specialty specific and general medical conditions. For our records and for treatment planning medical photographs are sometimes taken before, during and after a procedure or treatment. In addition we may request video media to accompany these photographs. These photographs support procedure planning and post-procedure evaluation. Photographs and/or videos are required only for the specific treatment areas. The images typically do not include the face. Consent is required for all patient imaging by Delaware Center of Excellence in Obstetrics and Gynecology, P.A.

Additionally, patients can consent to the release of these photographs and/or videos for potential use in instructional, educational, or promotional materials. These visual materials support our continuing need to insure our current and future patients receive the best treatment and to allow our future patients to understand the planned procedures and, through the use of the visual materials, understand the potential treatment results.

Please read the following release approvals carefully and provide your consent where applicable.

***A signature in section 1 is required to receive your care at* Delaware Center of Excellence in Obstetrics and Gynecology, P.A**. ***Your signature in section 2, while encouraged, is optional.***

**SECTION 1: CONSENT TO TAKE PHOTOGRAPHS AND/OR VIDEOS**

I hereby authorize Delaware Center of Excellence in Obstetrics and Gynecology, P.A. to take pre- procedural, and post-procedural photographs, and/or videos.

I consent to the use of these images for the purposes of pre-procedural planning and post-procedural evaluation by Delaware Center of Excellence in Obstetrics and Gynecology, P.A. treatment team.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Print Name) understand that the photographs and/or videos will be made a part of the medical record.

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Parent or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If Patient is under 18 years of age):

**SECTION 2: CONSENT FOR RELEASE OF PHOTOGRAPHS AND/OR VIDEOS**

I hereby authorize Delaware Center of Excellence in Obstetrics and Gynecology, P.A. to use any previously defined photographs and/or videos for professional medical or promotional purposes including but not limited to display by electronic media for training, professional and/or lay publications, presentations to medical or lay groups, or promotional purposes.

Neither I nor any member of my family will be identified by name at any time. Unless it is necessary to include it, my face will not appear in the images. I understand that in some instances the images may portray features, which could make my identity recognizable.

I understand my participation is voluntary. I will not be entitled to financial compensation or any other consideration as a result of any use of these images and I hereby release Delaware Center of Excellence in Obstetrics and Gynecology, P.A. and any third parties involved in the creation or publication of professional and/or marketing materials, from liability for any claims by me or any third party in connection with my participation. I may rescind this permission at any time to prohibit future use by direct written communication with Delaware Center of Excellence in Obstetrics and Gynecology, P.A. management.

\_\_\_\_\_I decline to release any photographs and/or videos for non-treatment specific uses by Delaware Center of Excellence in Obstetrics and Gynecology, P.A..

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Print Name) understand that I am releasing the right to Photograph and/or video distribution to Delaware Center of Excellence in Obstetrics and Gynecology, P.A..

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Parent or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if Patient is under 18 years of age):