COVA OBGYN, LLC

Date: _____

NEW PATIENT INFORMATION

PLEASE PRINT AND COMPLETE ALL ENTRIES				
PATIENT LEGAL NAME (LAST -- FIRST -- MIDDLE INITIAL)		ADDRESS		
CITY, STATE		ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married ☐ Other_____	
PATIENT EMPLOYER NAME	OCCUPATION			EMPLOYER PHONE

INSURED/RESPONSIBLE PARTY INFORMATION				
NAME (FIRST -- LAST -- MIDDLE INITIAL)		RELATION TO PATIENT: ☐spouse ☐parent ☐guardian		
HOME PHONE	WORK PHONE	ADDRESS (if different from patient)		
		SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION (Please give your insurance card to the receptionist)			
PRIMARY INSURANCE NAME	ADDRESS (if different)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
PRIMARY DOCTOR/FAMILY DOCTOR		REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP	PHONE NUMBER

SECONDARY INSURANCE INFORMATION (if applicable)			
PRIMARY INSURANCE NAME	ADDRESS (if different)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

Email Address: _____ Would you like to be added to our newsletter? Y / N

Ethnicity: ☐Non-Hispanic ☐Hispanic ☐Other

Race: ☐African-American/Black ☐Caucasian/White ☐Native American ☐Asian ☐Other

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Cova ObGYN, LLC or the insurance company to release any information required to process my claim.

X_____

Patient/Guardian Signature Date: _____

COVA OBGYN LLC HIPAA POLICY
USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AGREEMENT

This disclosure contains information regarding the privacy of your personal healthcare information. Please read it carefully before signing. Cova OB/GYN, LLC will not condition treatment by your failure to sign this disclosure.

By signing this disclosure I acknowledge that Cova OB/GYN, LLC may use or disclose my medical information for the purpose of my treatment or obtaining payment for services rendered. I am aware that Cova OB/GYN,LLC may disclose my medical information to a *Business Associate* for the same reasons, and that the *Business Associate* will be bound by all appropriate legal restrictions.

Further, by signing this document I acknowledge that I have been provided a copy of and have read the Notice of Privacy Practices containing a complete description of my rights, and the permitted uses and disclosure, under HIPAA.

Acknowledged and agreed to by:

Patient: _____ or Representative: _____

Signature: _____ Date: _____

The Federal Government now restricts this office and Cova OB/GYN, LLC from discussing your health information and condition with other family members or person unless you specifically give your written permission.

By my signature below, I grant Cova OB/GYN, LLC permission to discuss my protected medical information with the following individuals:

_____ _____
Name Relationship

_____ _____
Name Relationship

Signature of Patient: _____ Date _____

Please list daytime telephone number at which you prefer to be reached. _____

Can we leave a message regarding your protected health information at the number you have provided? ☐Yes ☐No

Would you like to be subscribed to our Newsletter? ☐Yes ☐No Please provide email: _____

Financial Policy

Thank you for choosing Cova OB/GYN, LLC as your health care provider. We are committed to providing you with the best possible health care. The following information is provided to ensure you are aware of and understand our financial policies.

Our office participates with a variety of insurance plans. It is your responsibility to:

***Bring your insurance card to every visit**
***Be prepared to pay your co-pay at the time of service or to pay in full if you do not have coverage for your visit. If you have a high deductible or coinsurance, a deposit of $75 is required.**
***If you have received a statement, please be prepared to pay any outstanding balance.**
***All outstanding balances need to be paid within 90 days of service.**
***Effective January 1st, 2017, no payment plans are accepted.**

Please understand that medical insurance is a contract between you and your insurance company. As a courtesy, we will file the claims to your insurance and diligently work to receive payment. It is your responsibility to know limitations, exclusions, deductibles and co-pays, of your insurance plans. Any deposits that are paid, will be subtracted from the total amount you owe, once processed by your insurance company. If copayments and/or deposits are not paid at the time of service, the appointment may be cancelled. We accept cash, checks, Visa, MasterCard, and Discover for your convenience.

If a patient is a minor (18 years and younger) and is using a parent's insurance benefit, the parent or guardian must sign below. The parent or guardian is responsible for any payment due at the time of service.

Surgical Services and Office Procedures

Insurance benefits will be verified prior to all elective and non-elective scheduled procedures. Although we may have been informed by your insurance company that you have coverage, this does not mean the procedure will be paid. A deposit of at least $250 is required prior to surgery scheduled at the hospital, in the event of outstanding deductible and/or coinsurance. In office procedures require deductible and coinsurance portion to be paid up front. There is never a guarantee of payment until the claim is processed. In the event the insurance does not pay, services will be billed directly and payment will be expected. If you do not have coverage for the benefit at all, full payment is required prior to the procedure. Cancellation of surgery must be provided up to one week in advance or may be charged a cancellation fee of $75, and possible dismissal from the practice.

Compliant Coding

Please be aware that some, and perhaps all, services rendered may not be considered payable under some insurance policies. You will be responsible for these balances. Some insurance companies do not cover preventative care, such as annual exams. Medicare will only cover a routine gynecological exam every 2 years. Routine and preventative services cause confusion for many patients. It is not uncommon for patients in the course of a visit to receive both treatment for a problem and preventative services. When this occurs, proper coding will be used which may result in a charge for both services. Your individual contract with your insurance carrier will determine how your insurance will pay. We make every effort to bill each visit with the proper diagnosis and procedure codes according to national coding guidelines. Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical record.

Laboratory Fees

Most laboratory charges, such as blood work, PAP and pathology tests, ordered through our office are billed directly to your insurance by LabCorp. **It is patient responsibility to notify the staff if your insurance requires specific lab.** There are special lab services that are sent to labs that may be considered out of network. In most cases, those labs have a contract only billing the patient for a set price. Our office will notify you of those prices at the time of service. If you receive a statement from any of these laboratories, we request that you contact them directly to resolve any billing questions.

Missed Appointments

We appreciate your help and a courtesy call if you are unable to keep your scheduled appointment. Please notify our office at least 24 hours prior to your scheduled appointment to avoid a $25 cancellation fee. Multiple cancellations or no shows may be subject to dismissal from the practice.

Other Fees

There will be a $30.00 fee for any returned checks. Paperwork (FMLA, short term disability, etc...) requiring completion will be charged a flat fee of $25, due at time of request.

Obstetrical Care

Please be advised of COVA OB/GYN's office policy concerning your pregnancy and insurance coverage. Unlike other types of services, prenatal care is billed globally and will be billed at the end of your pregnancy, after delivery. In the event of an insurance change, the global fees, may need to be billed separately to the covered insurance at the time services were rendered. Prenatal care includes your routine office visits and delivery charges. During your pregnancy, physicians may order additional studies, such as ultrasounds or non-stress tests and labs. These services will be billed to your insurance at the time of the service, and are not included in the global prenatal care fee. Additionally, if you are seen for any problem or condition unrelated to your pregnancy, we are required to bill for the office visit. You may be responsible for co-pays and/or additional fees for these services, which will be determined by your contract with your insurance.

Please be aware of the cost of delivery. Some insurance companies apply part of the delivery charges as a co-insurance and/or deductible. This balance is considered part of the total reimbursement to the doctor, and will be your responsibility. After your initial obstetric visit, you will be provided a reference sheet to call your insurance and find out what your benefits are for prenatal/care and delivery. Once returned, our office will confirm your benefits and make you aware of your approximate responsibility. **Pre-payment may be required by the end of the 32nd week of pregnancy.**

It is your responsibility to inform our office of any changes in your insurance.
I have read and understand the above information and agree to comply with these financial policies.

Signature_____ Date_____

Patient Name_____