PATIENT REGISTRATION

First Name _____ Middle _____ Last _____

Home Address _____ Apt. # _____

City _____ State ____ Zip _____ Sex _____ Date of Birth _____

Phone (Home) _____ Cell _____ Work _____

Referred By: _____ Marital Status: ____S ____M ____W ____D

EMPLOYMENT: ____ Student ____ Retired ____ Unemployed ____ Self-Employed ____ Employed

Employer _____ Occupation _____

Your Email: _____

Spouse's Name: _____ Phone # _____

Emergency Contact: _____ Phone # _____

INSURANCE INFORMATION / RESPONSIBLE PARTY

Primary
Insurance Company _____ Phone # _____

Policy # _____ Group # _____

Card Holder's
First Name _____ Middle _____ Last _____

Date of Birth _____ Sex _____

Relationship to Patient _____ Self _____ Spouse _____ Parent _____

Employer _____ Phone # _____

Secondary Insurance _____ Phone # _____

Policy # _____ Group # _____

Card Holder's
First Name _____ Middle _____ Last _____

Date of Birth _____ Sex _____

Relationship to Patient _____ Self _____ Spouse _____ Parent _____

Employer _____ Phone: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non covered services.

_____ _____
Signature Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____ _____
Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Greater Houston OB/GYN, LLP
929 Gessner Rd, Suite 2150
Houston, Texas 77024
(713) 935-9791

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

I hereby authorize Greater Houston OB/GYN L.L.P to release information regarding test results and to discuss any treatment for my care received in your office with the following friend(s) and/or family member(s).

I additionally request that this person or persons have the availability to discuss any billing issues for the treatment that I have received.

Name or names: _____

_____

Patient Name (please print): _____ Today's Date: _____/_____/_____

Signature: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reasons:

GREATER HOUSTON OB/GYN, L.L.P.
Memorial Hermann Tower
929 Gessner, Suite 2150
Houston, Texas 77024-2414

No-Show, Late, and Appointment Cancellation Policies

Please be advised that we require notice of at least 24 hours to reschedule or cancel an appointment. Changes to scheduled appointments must be made by calling the office during our normal business hours.

No-Show Appointments

Our office policy provides for a charge of **$50 for No-Show Appointments**, which are defined as any of the following:

- Patient reschedules or cancels an appointment fewer than 24 hours in advance

No-show appointment fees will be charged to your account. Payment of no-show fees is required prior to scheduling future appointments.

Late Arrival Policy

Patients who arrive more than 15 minutes late to an appointment or ultrasound may not be able to be seen on the day of the original appointment. Although we will make an effort to reschedule the appointment to the next available appointment that day or to an appointment with another provider, the appointment may need to be rescheduled to the next available appointment on another day.

Multiple No-Show, Rescheduled, or Cancelled Appointments

Patients with multiple no-show, rescheduled or cancelled appointments may be dismissed from the practice.

By signing below, please acknowledge your receipt of the information above. Thank you.

_____ _____

Patient Name **Date**

_____

Patient Signature/Parent or Guardian Signature