# Emerson GYN Surgical Associates

**NAME**: _____**DATE OF BIRTH**:_____

**ADDRESS**:_____

**CITY**: _____ **STATE**: _____**ZIPCODE**: _____

**HOME PHONE#**:_____ **CELL PHONE#**:_____

**PREFERRED CONTACT**: HOME /CELL

**MAY WE CONTACT YOU AND LEAVE MESSAGES**? HOME : Y / N CELL: Y / N

**MARITAL STATUS**: S / M / W / DIV **PREFERRED LANGUAGE**_____

**RACE: _____ ETHNICITY:_____**

**WE ENCOURAGE YOU TO SIGN UP FOR OUR PATIENT PORTAL**? YES / NO

**EMAIL ADDRESS (Only if signing up for the Portal)**: _____

**PRIMARY CARE PHYSICIAN**: _____

****REFERRING PHYSICIAN**: _____

**PHARMACY NAME/TOWN**: _____

**MAIL ORDER PHARMACY**: _____

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****IF YOUR INSURANCE REQUIRES REFERRALS, YOU ARE RESPONSIBLE FOR OBTAINING THEM PRIOR TO YOUR APPOINTMENT. YOU WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED FOR UNAUTHORIZED CARE.**

**PRIMARY INSURANCE COMPANY: _____**

**SUBSCRIBER NAME**:_____**POLICY #**:_____

**SECONDARY INSURANCE COMPAY: _____**

**SUBSCRIBER NAME**:_____**POLICY #**:_____

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**WHOM MAY WE CONTACT IN THE EVENT OF AN EMERGENCY**? _____

**RELATIONSHIP TO PATIENT**:_____ **PHONE #**: _____

**MAY WE DISCUSS YOUR CONDITION WITH ANY MEMBER OF YOUR FAMILY**? Yes / No

**IF YES, WHO**_____ **PHONE NUMBER: _____**

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THIS INFORMATION IS GIVEN FOR THE PURPOSE OF ESTABLISHING AN ACCOUNT AND MEDICAL FILE WITH EMERSON GYN SURGICAL ASSOCIATES. IT IS UNDERSTOOD THAT I SHALL BE RESPONSIBLE FOR ALL CHARGES INCURRED BY ME (OR ANY MINOR CHILD AS NOTED ABOVE). I AUTHORIZE PAYMENT FOR ANY INSURANCE CLAIMS BE MADE DIRECTLY TO EMERSON PRACTICE ASSOCIATES, INC.

**PATIENT NAME: _____**

**PLEASE PRINT NAME:**

**SIGNATURE**: _____

**DATE**: _____

**PATIENT REPRESENTATIVE SIGNATURE IF PATIENT IS A MINOR OR UNABLE TO SIGN**:

_____

**RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT**:

_____

# Emerson GYN Surgical Associates

**SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION**

I understand that I have an obligation to obtain a referral from my Primary Care Physician for services.

I acknowledge that if I DO NOT have a referral today that I will be responsible for payment for services received should this be denied by my insurance carrier.

PATIENT NAME: _____ DOB: _____

PATIENT SIGNATURE: _____

DATE OF SERVICE: _____ DATE:_____

PATIENT REPRESENTATIVE SIGNATURE IF MINOR OR PATEINT IS UNABLE TO SIGN:

_____

RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT: _____

**EMERSON HOSPITAL**

**ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE**
**AND**
**CONSENT TO TREAT/ DISCLOSE HEALTH INFORMATION**

**ACKNOWLEDGMENT OF RECEIPT OF EMERSON'S NOTICE OF PRIVACY PRACTICES:**
By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Emerson Hospital, Emerson Practice Associates, Concord Gastroenterology Associates, any health care professional providing services in the Hospital's clinically integrated care setting, any members of our volunteer group that we allow to help you, and all employees, staff and other Emerson Hospital personnel (collectively, "Emerson")."

**CONSENT FOR TREATMENT/TO DISCLOSE MY GENERAL HEALTH INFORMATION:**
By my signature below, I hereby authorize Emerson Hospital and those physicians, assistants and consultants as may be selected by them to render such care including diagnostic procedures, medical and surgical treatment and emergent blood transfusions, which may be necessary to care for me. I also authorize Emerson Hospital to disclose my medical information so that Emerson may treat me, seek payment from third parties for such treatment, and generally carry on Emerson's health care operations (e.g., quality assurance). I also authorize Emerson to disclose my medical/insurance information to insurers and providers outside of Emerson when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations. I also authorize Emerson to send me information regarding health services at Emerson Hospital.

**ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY**

In consideration of services rendered, I hereby irrevocably assign and transfer to Emerson Hospital, its physicians, assistants and consultants rights, title and interests in the benefits payable for services rendered related to this visit. If I am covered under Medicare, I hereby certify that the information given by me in applying for payment under Title XV11 of the Social Security Act is correct. Said irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of Emerson Hospital to pursue any such right of recovery. Provided, however, this assignment and transfer shall not take away my standing to sue or make claim for benefits, individually, should coverage be denied by an insurance carrier(s). I hereby authorize my insurance company(ies) to pay directly to Emerson Hospital and its physicians, assistants, and consultants all benefits due under said policy(ies) by reason of services rendered therein. I will pay Emerson Hospital, its physicians, assistants, and consultants for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policy(ies) that my providers are permitted to collect. A photostatic copy of this authorization shall be considered as effective and valid as the original.

_____ _____

Print Name Date

_____

Signature of Patient

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

_____ _____

Signature of Personal Representative

Description of Authority: _____ Date: _____