

LIFETIME OB/GYN, LTD.

*****PLEASE PRINT ALL INFORMATION*****

Patient Name _____ Today's Date _____
Address _____ Date of Birth _____
City _____ State _____ Zip _____ SS# _____
Phone # _____ Work# _____ Cell# _____
Driver's License # _____ Expiration Date _____

Employer _____ Occupation _____

Marital Status (circle one): S M D W Separated Partners Name _____

E-mail Address (if you want to be included on our email contact list) _____

I, the undersigned, give permission to LifeTime OB/GYN, Ltd. to communicate written follow-up instructions, test results and educational materials via the email address provided above. I also understand the potential breaches of privacy and confidentiality that may occur through e-mail correspondence. **Signed** _____

PRIMARY INSURANCE INFORMATION

Name of Insurance _____ Policy/Group # _____

Subscriber ID # _____ Effective Date _____

Insurance card holder/Responsible Party _____ Relationship _____

Card Holder Phone Number _____ Work/Alt Number _____

Card Holder Address _____ SS# _____

City _____ State _____ Zip _____ Date of Birth _____

Employer _____ Occupation _____

SECONDARY INSURANCE INFORMATION

Name of Insurance _____ Policy/Group # _____

Subscriber ID # _____ Effective Date _____

Insurance card holder/Responsible Party _____ Relationship _____

Card Holder Phone Number _____ Work/Alt Number _____

Card Holder Address _____ SS# _____

City _____ State _____ Zip _____ Date of Birth _____

Employer _____ Occupation _____

Please turn page over to complete and sign.

LifeTime will bill the responsible party shown above as primary insurance card holder for all fees not paid by your insurance company. If you would like billing to be sent elsewhere, please provide an address at right.

*****Please note the insurance company will send all correspondence to the insurance policyholder. Most labs are billed separately.**

Who referred you to this office? _____

IMPORTANT INSURANCE INFORMATION

It is important that you be informed that even when you are covered by insurance, our professional services are provided and charged to you, not your insurance company. Some insurance plans only pay for a portion of the costs of services, some don't cover at all. You are responsible for any balance that your policy does not cover. **It is your responsibility to know your policy, its benefits and restrictions—including where lab work must be done or sent or the need for referrals.** We will prepare and submit your claim to your insurance carrier. If additional medical info is requested to process your claim, we will provide it.

- I understand this information is updated yearly and it is my responsibility to notify this office of any changes in my name, address, phone number or insurance carrier.**
- I authorize the release of any medical information required to process any claims for charges incurred.**
- I authorize payments to LifeTime OB/GYN, Ltd.**

Patient Signature: _____

Date: _____