

Mid-City OB-GYN, P.C.
7205 West Center Road, Suite 200
Omaha, Nebraska 68124

For Office Use Only		
Patient Account Number	Physician Number	Entry Number

Patient Information: Please complete the following information completely. Please present a copy of your insurance card to our staff. Also please produce a picture identification card so that we may positively identify you to keep your medical records safe.

Legal Name: _____
First Middle Last

Address: _____

City: _____ State _____ Zip _____

E-mail address: _____ How did you hear of us? _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Date of Birth: _____

Employer: _____

Emergency Contact: _____ Phone Number _____

IF THE PATIENT IS NOT THE PRIMARY CARD HOLDER, PLEASE FILL OUT THE FOLLOWING INFORMATION:

Insured Name: _____
First Middle Last

Insured SS# _____ Insured Date of Birth _____

Insured Employer: _____

Patient Relationship to Insured: _____ Phone Number _____

Your Insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay the deductible, co-pay, and any other balances not paid by your insurance company. We will assist in receiving reimbursement as much as possible, but you are ultimately responsible for your bill.

ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process claims and to ensure payment of services rendered.

I authorize release of all medical information necessary to process this claim.

I assign all medical benefits and/or surgical benefits including major medical benefits to which I am entitled to Mid-City OB-GYN, P.C.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

If it becomes necessary to assign this claim to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. WHETHER MY INSURANCE PAYS OR NOT DOES NOT AFFECT MY RESPONSIBILITY. I AUTHORIZE RELEASE OF ALL MEDICAL INFORMATION WHICH IS PERTINENT TO MY MEDICAL CARE. I HAVE READ THIS INFORMATION AND I UNDERSTAND IT.

PLEASE SIGN AND DATE BELOW:

Patient (Parent if Minor) _____ Date: _____

Responsible Party (if different than patient) _____ Date: _____