GAMA
Gynecology Aesthetic Medical Associates
Specializing in Women's Health

PATIENT REGISTRATION

Please print. All information will be confidential.

Patient Name _____ ( ) _____
Last First Middle Home Telephone Number

Address _____ City _____ State _____ Zip _____

Marital Status _____ SS# _____ Birthdate _____ Age _____ Home Phone # ( ) _____

Email Address _____ Cell phone # ( ) _____

Employer _____ Work Phone # ( ) _____

Address _____ City _____ State _____ Zip _____

Nearest Relative _____ ( ) _____
(Not Living with You) Name Relationship Telephone Number

Address _____ City _____ State _____ Zip _____

Person to contact in case of emergency _____ Phone # ( ) _____

RESPONSIBLE PARTY

_____ ( ) _____
Last Name First Middle Home Telephone Number

_____
Street Address City State Zip

INSURANCE INFORMATION

#1 Insurance Company _____ Insured Name _____

Insured Address _____ Insured Work Phone# ( ) _____

Employer Name _____ SS# _____ Insured Date of Birth _____ Relationship _____

#2 Insurance Company _____ Insured Name _____

Insured Address _____ Insured Work Phone# ( ) _____

Employer Name _____ SS# _____ Insured Date of Birth _____ Relationship _____

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I request all payments be made to GAMA, P.C., Inc. on my behalf for any services furnished to me by GAMA, P.C., Inc. I authorize the release of any medical or non medical information to appropriate agencies for the processing of benefits. I understand should I have insurance that I am ultimately responsible for all charges incurred at GAMA, P.C., Inc. I further understand should I default in payment, that I am responsible for any and all collection costs and/or attorney fees incurred. According to HIPPA guidelines, I acknowledge that I have had available and/or received the NOTICE OF PRIVACY PRACTICES from GAMA, P.C., Inc.

Patient Signature: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

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FINANCIAL POLICY

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GAMA, P.C., Inc., is committed to providing you with the best possible care. If you have medical insurance, we will assist you in receiving the maximum allowable benefits.

Payment for services is due at the time the services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, check, Visa, MasterCard, and Discover. We will provide an itemized statement to file with your insurance or file the claim for you. When we are contracted with your Insurance plan, we will collect according to the guidelines of your plan. We will collect co-payments, deductibles, and coinsurance owed by your, our patient, at the time of service.

We will discuss your proposed treatment and answer questions relating to the filing of your insurance. We would also like to remind you of the following:

- **Your insurance policy is a contract between you, your employer, and the insurance company.**
- **Our fees are generally considered to be within the acceptable range by most companies, and, therefore, are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse on a usual and customary schedule of fees which bear no relationship to the current standard and cost of care in this area.**
- **Not all services are covered benefit in all contracts, such as routine office exams. You will be responsible for these charges.**
- **If you participate in a managed care plan, where a referral from your primary care physician is required, it is your responsibility to provide our office with that referral at the time of your visit.**

We must emphasize, as your healthcare provider, our relationship is with you and not with your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are the patient's responsibility from the date the services are rendered. If we do not hear from the insurance company within six (6) weeks, the full balance becomes due and payable at that time. If payment arrangements have not been made and the full payment is not received 60 days after the date of service, your account may be turned over to an attorney or collection agency.

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I have read and understand the above financial policy. I understand that I am ultimately responsible for the balance on my account for professional services rendered by GAMA, P.C., Inc. I understand that if my account should be sent to collection or require litigation; I will be responsible for any and all legal and/or collection costs and/or attorney fees incurred. I understand my financial responsibility to GAMA, P.C., Inc., as described in this document.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN **DATE**

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Jeffrey R. Yessenow, M.D.

PERMISSION TO CONTACT OR LEAVE MESSAGE

With the enactment of the Health Insurance Portability and Accountability Act of 1996, GAMA, P.C., Inc. recognizes that a patient has the right to have his or her health information kept private and secure.

As part of GAMA, P.C., Inc. Quality Assurance Plan, we may find it necessary, at times, to call you or leave a message for you to call us.

_____ I grant permission for GAMA, P.C., Inc. to contact me regarding information that they might need for my care. <u>They may leave a message with a person at my home or leave a message on a recorder.</u>

_____ Yes, you may call, but speak only with me. <u>DO NOT LEAVE A MESSAGE.</u>

_____I prefer that you contact me only at this number:

Home: _____

Work: _____

Cell: _____

Other: _____

We are currently looking at different ways of communicating with our patients. At the present time these include text messages and emails for the purposes of health promotion and appointment reminders.

May we send you reminders via text message? ☐ Yes ☐ No Cell Phone:_____

May we communicate with you via email? ☐ Yes ☐ No Email Address:_____

_____ _____
Patient Name (Printed) **Date**

_____ _____
Patient (Signature) **Date**

_____ _____
Witness (GAMA, P.C., Inc.) **Date**

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How Did You Learn About Dr. Yessenow

☐ **My friend, _____, told me about Dr. Yessenow.**

☐ **My doctor, _____, referred me to this office.**

☐ **Your location is convenient to my home or office.**

☐ **I visited your web site.**

☐ **Used search engine: Google, MSN, Yahoo Other: _____**

Keyword searched **_____**

☐ **My insurance web site: _____**

☐ **Hospital Referral: _____**

☐ **Outside office Sign:_____**

☐ **Other: _____**

Did you see or will you be seeing Dr. Yessenow at the Munster or Lowell Office?
(Please circle office)

Thank you for taking the time to complete this information.