GYNECOLOGY & OBSTETRICS ASSOCIATES OF TALLAHASSEE
CARING FOR GENERATIONS OF WOMEN

Patient Information

Last Name _____ First Name _____ Middle_____

Address _____ Apt_____ City_____ State _____Zip_____

Social Security #_____ Age_____ Date of Birth _____Marital Status_____

Email Address_____ Primary Phone # _____

Work Phone_____ Other Phone _____

Emergency Contact # _____ Emergency Contact Name_____

Primary Care Physician_____ Employer_____

Consent to Text ☐ Yes ☐ No Consent to Call ☐ Yes ☐ No Consent to Patient Portal ☐ Yes ☐ No

Responsible Party Information

Signature authorization for assigned or unassigned claims: I hereby authorize any holder of medical or other information about me to release to my insurance carriers any information needed for this or any future medical claim. I permit a copy of this authorization to be used in place or the original and request payment of medical insurance benefits of the patient who accepts care or services. I understand that I am required to pay for any health insurance deductibles, copays, co-insurance, self-pay charges or any other charges incurred which are not paid by my insurers or third party. I understand that if I have unpaid balances beyond 90 days, the responsible party will be sent to collections and I will not be seen again for care until the balance is paid in full.

Full Name_____ Address_____

City_____ State_____ Zip_____ Phone #_____

Signature_____ Date_____

No-Show/Cancellation Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Gynecology & Obstetrics Associates of Tallahassee reserves the right to charge a fee of **$35.00** for all missed appointments ("no-shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advanced notice. If a patient has two (2) appointments scheduled, such as an office visit and an ultrasound, a fee of **$50.00** will be charged for missed appointments without a 24-hour advanced notice. "No-show" fees will be billed to the patient. These fees are not covered by insurance and must be paid prior to your next appointment. Multiple "no-shows" or less than 24-hour notice cancellations in any 12 month period may result in being discharged from the practice. Thank you for understanding as we strive to best serve the needs of all our patients. By signing below, you acknowledge that you have received this notice and understand this policy.

Print Full Name_____ Signature _____ Date_____