PREMIER OB/GYN, LLC
DECCA MOHAMMED, MD

PLEASE FILL OUT ALL (3) SHEETS

PATIENT NAME _____SS# _____

BIRTHDAY_____STREET ADDRESS _____ APT# _____

CITY_____ STATE _____ZIP CODE _____ .HOME#_____

WORK# _____ CELL PHONE#_____

MARTIAL STATUS: S M W SEP D

NAME OF PCP _____ telephone _____ address _____

*PHARMACY NAME*_____ADDRESS_____PHONE#_____

PATIENT EMPLOYER _____

EMPLOYMENT ADDRESS _____

SPOUSE NAME _____

SPOUSE BIRTHDATE _____

SPOUSE EMPLOYER _____

EMPLOYMENT ADDRESS _____

EMERGENCY CONTACT _____ HOME# _____

PRIMARY INSURANCE _____

POLICY # _____ GROUP # _____

NAME OF INSURED _____ RELATION _____

ADDITIONAL INSURANCE _____

POLICY # _____ GROUP # _____

NAME OF INSURED _____ RELATION _____

MEDICARE# _____ MEDICAID# _____

DO YOU HAVE ADVANCED DIRECTIVE OR A LIVING WILL? YES NO

WHOM SHOULD WE THANK FOR REFERRING YOU? _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Mohammed to release any medical or incidental information that may be necessary for either medical care or in processing application financial benefits.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Mohammed for services rendered by her in person or under her supervision. I understand I am financially responsible for any balance not covered by my insurance.

IN CONSIDERATION OF ANY CREDIT EXTENDED TO ME AND MEMBERS OF MY FAMILY, I AGREE TO BE RESPONSIBLE FOR ALL CHARGES AGAINST THIS ACCOUNT AND AGREE TO PAY IN ACCORDANCE TO THE FOLLOWING TERMS:

1. ALL ACCOUNTS ARE DUE WITHIN 30 DAYS. FINANCE CHARGES OF 1.5% (18% ANNUM) WILL ACCRUE AND BE PAYABLE ON BALANCE OUTSTANDING OVER 30 DAYS.
2. I UNDERSTAND THAT A COLLECTION FEE REPRESENTING 1/3 OF THE OUTSTANDING BALNACE BE ADDED IF REFFERED FOR COLLECTION TO AN ATTORNEY OR OUTSIDE AGENCY.
3. ANY RETURNED CHECKS ARE SUBJECT TO A SERVICE CHARGE OF $25 IN ADDITION TO A BALANCE DUE.

PATIENT SIGNATURE _____ DATE _____

PATIENT/ GUARDIAN/ SPOUSE _____ DATE _____

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