PREMIER OB/GYN, LLC

DECCA MOHAMMED, MD

PLEASE FILL OUT ALL (3) SHEETS

PATIENT NAME _____SS#_____

STREET ADDRESS _____APT#_____CITY_____STATE_____

ZIP CODE_____HOME#_____WORK#_____

BIRTHDATE_____MARITAL STATUS: S M W SEP D

NAME OF PCP_____telephone_____address_____

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 applications for financial benefits.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgica/medical benefits to Dr. Mohammed for services rendered by her in person or under her supervision. I understand that 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 BALANCE BE ADDED IF REFERRED 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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