Aster OB/GYN

Section I: Patient Information Date_____

Name:_____ I Prefer to be called: _____

Address:_____Apt_____City:_____State:_____Zip_____

Email Address_____ Would you like to communicate with the doctor via email? ☐ Yes ☐ No

Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____ Social Security Number:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation:_____ Employer_____ Work Phone_____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____ Date of Birth: _____

Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Employer_____ Work Phone (____)_____ SSN#_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ _____ Ins Co. Phone:_____

DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, please provide the information

Name of Insured_____DOB_____Relationship to Patient _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ _____ Ins Co. Phone:_____

240 W. 98th Street, Ste. 1E, New York, NY 10025 - 212-662-6100 - 212-662-6101
www.asterobgyn.com

Aster OB/GYN

Thank you for choosing us for your medical care. We are committed to the success of your medical treatment and care and we understand that many patients find insurance coverage and financial responsibility issues complex and confusing. Because of this, we have outlined our Practice's financial policy in detail. If you have any questions about our policies, our staff is happy to assist you.

What Is My Financial Responsibility?

Your financial responsibility depends on a variety of factors, explained in the chart below:

IIF YOU HAVE…	WE WILL…	YOU ARE RESPONSIBLE FOR…
☐ Managed care plan with which the doctor has a contract.	Confirm eligibility on your behalf. Inform you of any services/fees not covered by your plan. We will file the insurance claim.	Obtaining referral authorization from your primary care physician if needed. Paying your deductible, copay and any services that are not covered by your plan, at the time of your visit.
☐ HMO plan with which the doctor DOES NOT have a contract.	Check eligibility on your behalf. Inform you of the cost of your visit and /or procedure. Work with your to settle your account.	Paying for services at the time of your visit or prior to your procedure if another payment arrangement has been set up.
☐ Out of network PPOs from which the doctor accepts payments.	Check eligibility on your behalf. Inform you of the cost of your visit and /or procedure. File the insurance claim on your behalf and work with your to settle your account.	Paying your portion of the claim after it's been processed by your insurance.
☐ Medicare / Medicaid	Work with you to settle your account.	Paying for services at the time of your visit or prior to your procedure.
☐ Uninsured or Major Medical only	Work with you to settle your account.	Paying for services at the time of your visit or prior to your procedure.

Patients Who Are Minors

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages, or must provide complete and accurate information about the guarantor on the insurance that will be billed.

I have read, understand, and agree to this Financial Policy. **I understand that charges not covered by my insurance company, as well as applicable copayment and deductible are my responsibility and are payable immediately upon receipt of patient statement.**

I understand that when my provider checks for insurance eligibility, the insurance company does not guarantee payment and that my insurance may cancel my policy retroactively and if my insurance denies payment, I am responsible for immediate payment of the care I received.

I authorize my insurance benefits to be paid directly to ASTER OB/GYN, P.C.. I authorize ASTER OB/GYN P.C. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

DATE SIGNATURE PRINTED NAME

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, acknowledge that I have been provided with a copy of Aster OB/GYN's privacy notice.

Signature Date Relationship to Patient

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