MID-SOUTH OB-GYN PLLC

Drs. Taylor, Greenwell, Carney, Neblett, Hinote, Johnson, Butawan-Ali

CHART #____________________

NAME ____
(Last Name) (First Name) (Middle Initial) (Age) (Date of Birth)

ADDRESS ____ (Street) (Apt. #)
____ (City) (State) (Zip Code)

Single ________ Married ________ Widowed ________ Separated ______ Divorced ______

SOCIAL SECURITY NO. ____________________ HOME PHONE (___) ____________ CELL PHONE (___) ____________

EMAIL: ____________________________ WORK PHONE (___) ____________ RACE/ETHNICITY: ____________

YOUR OCCUPATION ____________________________ EMPLOYER ____________________________

EMPLOYER'S ADDRESS ____
(Street) (City) (State) (Zip Code)

SPOUSE/GUARDIAN NAME ____________________ SPOUSE/GUARDIAN EMPLOYER ____________________

SPOUSE/GUARDIAN SS# ____________________ SPOUSE/GUARDIAN CELL PHONE (___) ____________

PHARMACY/LOCATION: ____________________ PHARMACY PHONE: (___) ____________

SPOUSE/GUARDIAN DATE OF BIRTH ____________ RESPONSIBLE PARTY (if patient is a minor) ____________

REFERRED BY: ____________________ PRIMARY CARE PHYSICIAN: ____________________

PERSON TO CONTACT in case of EMERGENCY ____________ RELATIONSHIP ____________ PHONE (___) ____________

PAYMENT IS DUE AT THE TIME OF SERVICE

It is patient's responsibility to furnish current, correct insurance information at the time of service.

INSURANCE INFORMATION

As a courtesy to you, we will be happy to file your insurance for surgery, delivery or office surgery with an assignment of benefits. Payment for services rendered to you, however, are ultimately the responsibility of the patient and not contingent upon insurance settlement. Please furnish the information below:

Primary Insurance ____________________ Secondary Insurance ____________________

Claims Address ____________________ Claims Address ____________________

____________________ ____________________

Policy ID# ____________ Group # ____________ Policy ID# ____________ Group # ____________

Effective Date ____________ Policyholder DOB ____________ Effective Date ____________ Policyholder DOB ____________

Policyholder Name ____________________ Policyholder Name ____________________

Employer & Address ____________________ Employer & Address ____________________

Is this through your employment? ____________ Is this through your employment? ____________

I accept personal responsibility for payment of the charges for services rendered to me. I authorize payment of medical insurance benefits to MID-SOUTH OB-GYN PLLC and authorize the release of any medical information that may be necessary to process the claim. I will be responsibe for the fee in excess of my insurance reasonable. **I also understand that I am responsible for any expense that may be incurred in collecting this account, not to exceed 40% of the balance due plus court costs and reasonable attorneys fees, should such action become necessary.**

TENNCARE ACKNOWLEDGEMENT: I understand that Mid-South OB-GYN PLLC does not participate with or accept TennCare. I attest that I am not covered by this medical plan.

____________________ Date

____________________ Signature

LIFETIME AUTHORIZATION TO FILE MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Women's Care Center of Memphis, MPLLC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature:______________________________ Date:____________________

Patient, Parent or Guardian

CONSENT FOR CARE

I hereby give my consent for treatment to Women's Care Center of Memphis, MPLLC, including treatment or services, and which may include but not be limited to laboratory procedures, examination, retrieval of medication history, medical treatment or procedures rendered for me/my dependent under the general and specific instructions of the patient's physician.

Signature:______________________________ Date:____________________

Patient, Parent or Guardian

If I am a minor or filing benefits through my parent's/guardian's insurance, I authorize you to release information concerning my medical care to my parent(s) or legal guardian indicated below.

Signature:____________________ ____________________ Date:____________________

Patient Parent/Legal Guardian

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

I authorize Women's Care Center of Memphis, MPLLC or any person designated by them, to obtain/release copies of my medical records to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on me/my dependent.

Signature:______________________________ Date:____________________

Patient, Parent or Guardian

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment to Women's Care Center of Memphis, MPLLC for services rendered to me or my dependent(s). I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and/or collection costs and legal fees incurred in any attempt to collect said balance.

Signature:______________________________ Date:____________________

Patient, Parent or Guardian

AUTHORIZATION TO LEAVE MESSAGE

I hereby authorize Women's Care Center of Memphis, MPLLC to leave a message regarding pending appointments and/or tests at this # ____________________. You may notify me of lab/test results or matters relating to my prescriptions and/or treatment by leaving me an e-mail at this e-mail address:____________________ or voicemail at this # ____________________ or (check all that apply): ____ with my spouse, or ______ a family member (please include name of spouse and/or family member):______________________________

Signature:______________________________ Date:____________________

Patient, Parent or Guardian

I have received the Privacy Notice. Signature:______________________________ Date:____________________

HERBERT A. TAYLOR, MD
THOMAS D. GREENWELL, MD
JUDI L. CARNEY, MD
PAUL D. NEBLETT, MD
CANDACE D. HINOTE, MD
MARY KATHERINE JOHNSON, MD
DOMINIQUE BUTAWAN-ALI, MD

6215 HUMPHREYS BLVD
SUITE 100
MEMPHIS, TN 38120

TennCare/Medicaid Testimony

Do you have insurance through TennCare/Medicaid? ________
i.e. Amerigroup, BlueCare, or Community Plan

Have you applied or are you planning to apply for TennCare/Medicaid coverage?
____

Our office IS NOT contracted with TennCare. In the event that you get on TennCare, this may result in provider/patient separation, resulting in discontinuance from our practice to a medical provider that is in network with TennCare. Also, if your commercial insurance benefits change in the middle of your pregnancy, please notify us immediately so we can update your policy and your OB Payment Plan.

I, hereby, verify that the above information is correct.

________________________ ________________
Signature **Date**

____
Print Name

Our office is not in network with any form of TennCare. Types of TennCare are listed above as: Amerigroup, BlueCare, and Community Plan. We do not accept TennCare as a Primary or Secondary payer.