

# North Pointe OB/GYN Associates, L.L.C.

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Patient's Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status (circle one): S M D W

Social Security No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_  
Last First Middle

Social Security No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Authorization to Treat Minor Child: \_\_\_\_\_  Mother  Father  Guardian

(Signature)

Person to Notify in Case of Emergency (not at same address): Name: \_\_\_\_\_

Phone Number (Home): \_\_\_\_\_ Relationship: \_\_\_\_\_

Doctor you are seeing: \_\_\_\_\_

Referred to the Doctor by: \_\_\_\_\_

## INSURANCE INFORMATION:

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Please give your insurance cards to the receptionist so we may keep a copy on file.

Policy Holder: Name: \_\_\_\_\_ Relationship to you: Self Spouse Child

Social Security No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

I hereby authorize North Pointe OB/GYN to furnish all information to insurance carriers and other health care providers concerning my illness and treatments and assign all payments for medical services rendered to myself or my dependents to North Pointe OB/GYN Associates, L.L.C. I understand that I am responsible for any amount not covered by insurance. This information includes Protected Health Information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# The Doctors and Staff of North Pointe OB/GYN Associates, L.L.C., Want You to Know How We Will Protect Your Private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

1. Give patients more control over their health information;
2. Set boundaries for the use and release of health records;
3. Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information;
4. Hold violators accountable, with civil & criminal penalties; and
5. Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients that we see after April 14, 2003 with our Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information. A copy of this Notice is posted by the waiting room, and a copy is available for you, if desired, at the check-in window.

Please sign below that we have made available a copy of the Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our office manager.

Additionally, by signing below I allow anyone who comes into the examination and/or consultation room with me to participate in examination(s) and or discussion regarding my health care while in my presence.

Thank you for your cooperation.

**I acknowledge that I have received a copy of North Pointe OB/GYN Associates, L.L.C.'s  
Notice of Privacy Practices and have been given an opportunity to ask questions.**

**Patient Name:** \_\_\_\_\_  
(Please Print)

**Signature of Patient or Personal Representative:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**If Personal Representative, give relationship to patient:**

\_\_\_\_\_