AULTMAN
MATERNAL-FETAL MEDICINE
A Member of Aultman Medical Group

Patient Medical Record Number:			
PATIENT INFORMATION		**FINANCIAL RESPONSIBILITY INFO**	
Patient Name:		Insurance Guarantor:	
Address		Address:	
Address 2		Address 2:	
City, St, ZC		City, St, ZC	
Home Phone:		Home Phone:	
Work Phone:		Work Phone:	
Cell Phone:		Cell Phone:	
Social Security No.		Social Security No.	
Birth Date:		Birth Date:	
Employer		Employer:	
Patient Account No:		**Referring Physician**	
Marital Status		**Primary Care Physician**	
E-Mail Address:			

Emergency Contact Name		**Relationship to Emergency Contact**	
Emergency Contact Number			
Spouse's or Guarantor Contact Number			

	PRIMARY INSURANCE	***SECONDARY INSURANCE***
Company Name		
Policy Holder Name		
Policy Holder Date of Birth		
Policy ID Number		
Group Number/Name		
Relationship to Policy Holder	Self Spouse Child Other	Self Spouse Child Other
Copay Amount		

****PLEASE READ SIGN WHERE INDICATED BELOW****

FINANCIAL RESPONSIBILITY: I certify the above information is correct. I understand that I am responsible for full payment of my bill in a timely manner. I authorize the release of any medical information necessary to process this claim. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and other health plans to Aultman Maternal Fetal Medicine.

Patient Signature _____ Date_____ Due one year from Date Below (annually)
Witness_____ Date _____

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I have reviewed the Consent to Use and Disclosure of Protected Health Information and give my permission to Aultman Maternal Fetal Medicine to use and disclose my health information in accordance with it.

Patient Signature _____ Date_____ HIPAA On File - Date Below
Witness_____ Date _____