NEW ENGLAND OB/GYN ASSOCIATES, INC.
REGISTRATION & CONSENT FORM

Your Information:

Name: _____
first middle initial last

Date of Birth: _____

Address: _____
Apt # or PO box street

Address: _____
City/town state zip

Phone numbers where we may contact you (and leave a message if necessary) regarding test results or appointments:

(cell) _____ (work) _____

(home) _____

☐ Check here if you would like to opt in for text message appointment reminders

Email address _____

Primary Care Physician Information:

Name: _____Telephone ( ) _____
First Last

Physician Address: _____

Emergency Contact Information:

Name:_____Telephone ( ) _____
First Last

Relationship to Patient: _____

Insurance Information:

Please give the Receptionist all your Insurance Cards to copy.

Policyholder Name: _____
First Last

Date of birth (if not patient): _____ Relationship to Patient: _____

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Until revoked in writing, my signature authorizes New England OB/GYN Associates, Inc. (NEOGA) to release any medical or other information for the purpose of treatment, payment, or health care operations, among other purposes (such as disclosures required by law and under certain special circumstances), as follows:

1. **Treatment**. NEOGA may use your protected health information (PHI) to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for NEOGA including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. **Payment**. NEOGA may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health care operations**. NEOGA may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. **Privacy Policy**. I have reviewed NEOGA's Confidentiality/Privacy Policy.

5. **Patients Rights and Responsibilities**. I have reviewed NEOGA's Patient's Rights and Responsibilities statement.

_____ _____
Patient Signature Date

May we share your protected health information with your spouse, significant other, or parent?

Please circle YES NO

If answered yes:

_____ _____
Name of party to share information with Relationship to patient

_____ _____
Patient Name (Print) Date of Birth

_____ _____
Patient Signature Date

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