

Please Print



Patient Information

Last Name		MI	First Name
Date of Birth	Sex	S M D W Marital Status	SSN
Address		City	State Zip
Employer		Work Phone	
Cell Phone	Home Phone	<input type="checkbox"/> Check if number is blocked.	E-mail address

Emergency Contact

Spouse Name	Employer	Work Phone
Name (Other Than Spouse)	Relationship	Phone

Guarantor / Primary Insurance

Relationship to Patient	Insurance Name	
Policy #	Group #	Co-pay
Last Name	First Name	MI
Date of Birth	SSN	
Address		City State Zip
Employer	Work Phone	Insurance Effective Date
Cell Phone	Home Phone	

Secondary Insurance Information

Relationship to Patient	Insurance Name	
Policy #	Group #	Co-pay
Last Name	First Name	MI
Date of Birth	SSN	
Address		City State Zip
Employer	Work Phone	Insurance Effective Date
Cell Phone	Home Phone	

Primary Care Physician / Pharmacy Information

Primary Care Physician	Street, City	Telephone
Pharmacy Name	Street, City	Telephone
Signature _____		

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This document contains important information concerning your financial responsibility for services received at

The Counseling & Gynecology Group.

Financial Guidelines for Health Care Service

Please present your insurance card at every visit. As a courtesy to our patients we will bill a number of insurance companies directly. If we bill your insurance company, you will be responsible for any co-payment or deductibles. If you have an insurance plan other than those whom we bill directly, or if you are self-pay, payment is due and payable at the time services are rendered. If your insurance changes at any time, please notify us immediately. It is your responsibility to obtain a new referral (if required) and verify your benefits and acceptance of your insurance plan **prior** to services being rendered. Failure to do so may result in denied claims which will then be your responsibility for payment. We have an obligation by contract with insurance companies to collect all co-pays at the time of service. We accept cash, check, MasterCard, VISA, or American Express. If you fail to pay your co-pay at the time of service, you will be charged \$10.00 for billing services. If you pay by check, and it is returned, it will be necessary to apply a \$25 fee.

initials

Primary Care Physician

It is important that you choose a primary care provider and establish a relationship with your physician and keep him/her informed of your medical history. Coordinate all your non-emergency care through your primary care provider and within your network of providers. If your insurance company requires a PCP to be chosen prior to receiving treatment, it is your responsibility to do so. If you fail to choose a PCP as required you may be held financially responsible. Standard Mass Health requires you to establish a relationship with a PCC. It is necessary for billing to have your referring MD PCC information. If you have not done this prior to your visit you may be denied services until such time you have established a PCC relationship; or you may self pay at the time of service.

initials (MH only)

Referrals & Specialty Care

Your insurance plan may require prior authorization to be obtained for certain services in order to provide reimbursement. Please contact your insurance company to determine referral requirements before receiving services. If the visit requires a referral, you are responsible for obtaining that referral through your primary care physician, or your insurance company, depending on your policy. You will be responsible for payment for services received without a referral.

Other Services, Laboratory & Pharmacy

Some insurance companies have identified specific laboratories, pharmacies, and/or X-ray providers they expect you to use. Please contact your insurance company to determine these arrangements. We will make every effort to assist you in obtaining these services from the preferred provider.

Non-covered Services

Please take time to read and understand the information provided to you by your insurance company including your member handbook. All insurance plans have limits on the services they cover and it is extremely important that you know your benefits, limitations and exclusions under your specific plan. If we bill your insurance and payment is denied, payment remains your responsibility.

Annual Physical Exam & Preventive Services

Many Insurance companies classify the following as preventive services; annual exam, routine pap smear, cholesterol screening, urinalysis, diabetic screening and any other screening due to family history of disease. In the event that your insurance company does not cover preventive exams, services or other office visits without a referral, you will be responsible for these services. If this is a concern to you, please discuss this with our office manager or the billing staff before seeking medical care. Please do not ask us to resubmit claims with new codes if the claim was accurately submitted the first time.

Failed Appointments

There is a failed appointment fee for failure to notify this office **one full business day in advance** of cancellation of appointments. Fees range from \$30 to \$60.

Additional Fees

There may be fees for any of the following: A) Special letter requests that are not within the normal scope of medical care for military, jury duty, work, or personal reasons that require a clinician's time; B) Duplicate prescription requests due to lost prescriptions; C) Refill requests that should have been requested at your last appointment; D) Re-billing of insurance claims due to your failure to present proper or current insurance information; E) Telephone management for a medical condition or modification to your treatment plan if you decline to come in for an available appointment.

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Billing

Our billing service, MBNE, Inc. is available to help you if you have any questions regarding your balance. They may be reached at 866.321.4198, Mon - Fri, from 8:00 AM to 4:00 PM. For questions regarding your policy, call the number located on your insurance card.

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Assignment of Benefits

The Non-Medicare Patient: I authorize the release of all medical information necessary to process this claim and is pertinent to my medical care. I assign all medicare and/or surgical benefits including major medical benefits to which I am entitled to The Counseling & Gynecology Group.

The Medicare Patient: I request that payment of authorized Medicare/ Medigap benefits be made on my behalf to the Counseling & Gynecology Group for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents or my Medigap Insurer _____, any information needed to determine benefits or the benefits payable for related services.

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I certify that the information given by me is correct. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read the attached information and I understand that I am financially responsible for any account balance not paid by my insurance carrier.

Patient _____ Date _____

Parent or Guardian _____ Date _____