



GAMA

Gynecology Aesthetic Medical Associates

PATIENT REGISTRATION

PATIENT NAME: _____ ()
Last First Middle Home Telephone Number

ADDRESS: _____
Street City State Zip

EMAIL ADDRESS: _____

MARITAL STATUS: _____ BIRTH DATE: _____ AGE: _____ SEX: _____ RACE: _____

SOCIAL SECURITY#: _____ REFERRED BY: _____

EMPLOYER: _____ TELEPHONE NUMBER: ()

ADDRESS: _____
Street City State Zip

NEAREST RELATIVE: _____ ()
(Not Living with You) Name Relationship Telephone Number

ADDRESS: _____
Street City State Zip

RESPONSIBLE PARTY

_____ ()
Last Name First Middle Home Telephone Number

Street Address City State Zip

INSURANCE INFORMATION

#1 Insurance Company Insured Name

Insured Address Insured Home Telephone/Work Telephone

Employer Name Social Security Insured Date of Birth Relationship

#2 Insurance Company Insured Name

Insured Address Insured Home Telephone/Work Telephone

Employer Name Social Security Insured Date of Birth Relationship

I request all payments be made to GAMA, P.C., Inc., on my behalf for any services furnished to me by GAMA, P.C., Inc. I authorize the release of any medical or non medical information to appropriate agencies for the processing of benefits. I understand should I have insurance that I am ultimately responsible for all charges incurred at GAMA, P.C., Inc. I further understand should I default in payment, that I am responsible for any and all collection costs and/or attorney fees incurred. According to HIPPA guidelines, I acknowledge that I have had available and/or received the NOTICE OF PRIVACY PRACTICES from GAMA, P.C., Inc.

PATIENT SIGNATURE: _____ DATE: _____



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FINANCIAL POLICY

GAMA, P.C., Inc., is committed to providing you with the best possible care. If you have medical insurance, we will assist you in receiving the maximum allowable benefits.

Payment for services is due at the time the services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, check, Visa, Mastercard, and Discover. We will provide an itemized statement to file with your insurance or file the claim for you. When we are contracted with your insurance plan, we will collect according to the guidelines of your plan. We will collect co-payments, deductibles, and coinsurance owed by you, our patient, at the time of service.

We will discuss your proposed treatment and answer questions relating to the filing of your insurance. We would also like to remind you of the following:

- ◆ Your insurance policy is a contract between you, your employer, and the insurance company.
- ◆ Our fees are generally considered to be within the acceptable range by most companies, and, therefore, are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse on a usual and customary schedule of fees which bear no relationship to the current standard and cost of care in this area.
- ◆ Not all services are covered benefit in all contracts, such as routine office exams or home health visits. You will be responsible for these charges.
- ◆ If you participate in a managed care plan, where a referral from your primary care physician is required, it is your responsibility to provide our office with that referral at the time of your visit.

We must emphasize, as your healthcare provider, our relationship is with you and not with your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are the patients responsibility from the date the services are rendered. If we do not hear from the insurance company within six (6) weeks, the full balance becomes due and payable at that time. If payment arrangements have not been made and the full payment is not received 60 days after the date of service, your account may be turned over to an attorney or collection agency.

I have read and understand the above financial policy. I understand that I am ultimately responsible for the balance on my account for professional services rendered by GAMA, P.C., Inc. I understand that if my account should be sent to collection or require litigation, I will be responsible for any and all legal and/or collection costs and/or attorney fees incurred. I understand my financial responsibility to GAMA, P.C., Inc., as described in this document.

SIGNATURE OF PATIENT/GUARDIAN

DATE



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REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby request that my medical records be released to Dr. Jeffrey Yessenow for continuation of care at:

GAMA, P.C., Inc.
9250 Columbia Ave., Ste 2A
Munster, IN 46321
Phone: (219)513-1300
Fax: (219)513-2385

REQUESTING RECORDS FROM:

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax: _____

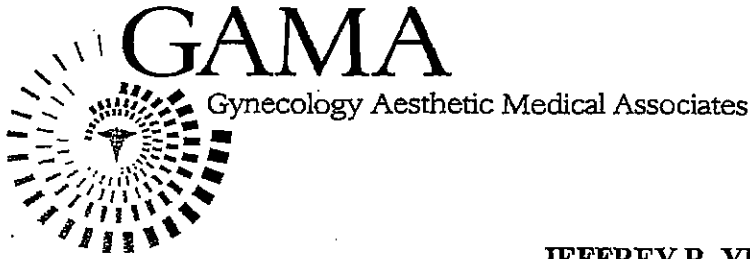
PATIENT INFORMATION:

Patient Name (print): _____

DOB: _____ Social Security Number: _____

I hereby authorize and consent to disclosure of health records as stated above. I am aware that the records disclosed might be records whose confidentiality is protected by either Federal Regulations (42 C.R.F., Part 2) or State Regulations (I.C. 16-39-16). The records may include alcohol and/or substance abuse and mental health documentation as well as HIV results.

PATIENT SIGNATURE: _____



JEFFREY R. YESSENOW, M.D.

PERMISSION TO CONTACT OR LEAVE MESSAGE

With the enactment of the Health Insurance Portability and Accountability Act of 1996, *GAMA, P.C., Inc.* recognizes that a patient has the right to have his or her health information kept private and secure.

As part of *GAMA, P.C., Inc.* Quality Assurance Plan, we may find it necessary, at times, to call you or leave a message for you to call us.

_____ I grant permission for *GAMA, P.C., Inc.* to contact me regarding information that they might need for my care. They may leave a message with a person at my home or leave a message on a recorder.

_____ Yes, you may call, but speak only with me. Do not leave a message.

_____ I prefer that you contact me only at this number:

Home: _____

Work: _____

Other: _____

Patient Name (Printed) Date

Patient (Signature) Date

Witness (GAMA, P.C., Inc. Staff) Date

How Did You Learn About

Dr. Yessenow?

- My friend, _____, told me about Dr. Yessenow.
- My doctor, _____, referred me to this office.
- Magazine Ad
- Newspaper Ad
- Your location is convenient to my home or office.
- I visited your web site.
- Used search engine: Google, MSN, Yahoo Other: _____
Keyword searched _____
- Referred by another web site: _____
- Other: _____

Thank you for taking the time to complete this information.