



Date: / /2014

Patient Information:

Name:		Doctor:	
DOB:	SSN#:	Patient Phone#:	
Street Address:			State:
City:		Zip Code:	
Employer:		Work #:	

Emergency Contact Information:

Name:	Relationship:
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Insurance Information:

Name of Insurance:	
Subscriber ID#	Group ID#
Secondary Insurance:	

Written Acknowledgment Receipt of IVWU Notice of Privacy Practices

I, _____, have received a copy of Inner Vision Women's Ultrasound Notice of Privacy Practices.
Patient Signature or Guardian of Minor

Important Patient Information:

- Allergies** – Please inform your sonographer if you are allergic to latex, iodine or other substances
- All Cell Phone** use is prohibited once the patient is taken back to the exam room
- Guests** are limited to two during exams and must all enter the room with the patient at one time
- Children** ages 4 and under must have an adult to accompany them during your exam

Financial Policy:

Please review the following information to help you make an informed decision & understand your financial rights & responsibilities pertaining to your healthcare choices to avoid any confusion/delays in the services you are scheduled for.

- All patients must provide a copy of their Insurance Benefits Card at time of check-in.
- IVWU reserves the right to discontinue care for any patient due to non-payment.
- Patients requiring services due to an injury that involves a third party account will be responsible for their own account.
- A \$25 service charge will be applicable for returned checks in addition to any charges assessed by your financial institution.
- As the patient, or guardian, you are responsible for knowing your benefits, including any co-payments, requirements for specialist referrals & any benefit exclusions. Please contact your insurance company regarding your coverage or benefits.
- The person receiving treatment or the guardian of a minor bears the financial responsibility for the services provided. If the treatment or services are court ordered, the financial responsibility must be determined between the two parties involved without the inclusion of IVWU.
- All patients with insurance requiring a referral for OB/GYN services are required to present a copy of the referral before services are provided. All patients seeking service without a referral will be required to pay for the service in advance or reschedule their appointment.
- IVWU will make every reasonable effort to collect payment on a patient's account before turning it over to collections. If an account is turned over to collections due to non-payment, no further services will be rendered, regardless of insurance coverage until payment in full is received. All associated legal and collection fees incurred in collecting on the account will be the responsibility of the patient.
- IVWU is not responsible for replacing any lost or damaged pictures that are given to you. IVWU will provide a one time DVD of the Anomalies Exam, however IVWU is not responsible for any faulty, damaged, or lost DVDs.

X

Patient Signature or Guardian of Minor

Relationship to Patient if Guardian

Date

