

DATE _____ HOME PHONE _____

NAME _____ WORK PHONE _____

ADDRESS _____ CITY _____ ZIP _____

YOUR SS# _____ DATE OF BIRTH _____ DRIVER'S LIC# _____

EMPLOYER _____ INSURANCE _____

HUSBAND'S NAME _____ HUSBAND'S
EMPLOYER _____

HUSBAND'S DOB _____ HUSBAND'S SSN# _____

NOTIFY IN CASE OF EMERGENCY:

NAME _____ RELATIONSHIP _____

PHONE _____

I UNDERSTAND THAT THERE WILL BE A \$25.00 CHECK CHARGE FOR ANY
RETURNED CHECK. IF THIS WAS A BANK ERROR, A LETTER FROM THE BANK
WILL BE REQUIRED TO WAIVE THE \$25.00 FEE.

SIGNATURE _____ DATE _____

REFERRED BY: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

OB/GYN Associates of Chico reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE:

I have received a copy of the Notice of Privacy Practices for OB/GYN Associates of Chico.

Signature of Patient

Date

I agree that OB/GYN Associates of Chico may:

- Call my home or work for appointment reminders
 - Send postcards to my home address for appointment reminders
 - Leave messages on answering machines at home or work for appointment reminders
 - Leave messages on answering machines at home or work advising me to call OB/GYN Associates of Chico for information (REMINDER: medical information will not be left on answering machines)
 - Send sealed letters to my home address with protected health information (For example: result of tests that you have requested)
 - I restrict information transfer to:**
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