Louisville Women's HealthCare

University
OB/GYN Associates

☐ 601 South Floyd St.
Suite 300
Louisville, KY 40202
Phone (502) 271-5999
Fax (502) 271-5994

☐ BROWN CANCER CENTER
529 South Jackson St.
3rd Floor
Louisville, KY 40202
Phone (502) 561-7220
Fax (502) 561-7327

☐ IN VITRO FERTILIZATION CENTER
315 E. Broadway
Suite 1105
Louisville, KY 40202
Phone (502) 271-5999
Fax (502) 271-5994

You have an appointment with Dr.________________ at __________ on __________ at above ✔ location.

Please complete this form and mail to our office for the enclosed envelope BEFORE your APPOINTMENT DATE. Thank you.

☐ New Patient ☐ Form Revision

PLEASE PRINT ENTIRE FORM

Referred By ______________________

Patient Name ______________________

Soc. Sec. #________ /________ /________

Address ______________________

Birth Date ______________________

City__________ St.______ Zip________

Hm. Phone (___)________ Wk. Phone (___)________

Employer ______________________

Occupation ______________________

Spouse (Parent) ______________________

Birth Date ______________________

Employer ______________________

Address ______________________

Hm. Phone (___)________ Wk. Phone (___)________

Occupation ______________________

Soc. Sec. #________ /________ /________

Name of nearest relative
not living with you ______________________

Relationship ______________________

Address ______________________

Hm. Phone (___)______________________

City__________ St.______ Zip________

Please provide all pertinent information regarding your insurance coverage. If you have coverage by more than one company please supply information regarding both companies.

Insurance Co. ______________________

Address ______________________

Insured Person ______________________

Policy Holder ______________________
Company

Patient is: ☐ Spouse ☐ Son ☐ Daughter ☐ Other

Group #__________ Certificate #__________

Effective Date ______________________

Insurance Co. ______________________

Address ______________________

Insured Person ______________________

Policy Holder ______________________
Company

Patient is: ☐ Spouse ☐ Son ☐ Daughter ☐ Other

Group #__________ Certificate #__________

Effective Date ______________________

ASSIGNMENT OF INSURANCE BENEFITS

I authorize direct payment of surgical/medical benefits to University OB-GYN Associates, P.S.C. for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize University OB-GYN Associates, P.S.C. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

REFERRALS

YOU ARE RESPONSIBLE FOR OBTAINING YOUR REFERRAL TO OUR OFFICE AND WILL BE RESPONSIBLE FOR ANY DENIED CHARGES WHEN THIS IS NOT OBTAINED.

A photocopy of these assignments shall be valid as the original.

Signature ______________________________ Date ______________

Patient (Please Print) ______________________________