

ATLANTA GYNECOLOGY & OBSTETRICS, P.C.
PATIENT INFORMATION

NAME/PT. #: _____ AGE: _____

I am here today for: an annual check-up a problem both

If you are here for a problem, please describe: _____

IMPORTANT INFORMATION:

Please be aware that some insurance plans:

- Only pay for preventive/screening visits and tests
- Others only pay for problem visits and tests
- Some pay for both
- Some will pay a certain percentage of the charges, leaving you responsible for the balance
- You may receive a bill from the lab or our office for the portion of your care not covered by your insurance
- If you have questions regarding your plan/coverage, please contact your insurer directly by using the phone number on your card before calling our office.

Please read the following 3 statements below and initial each one:

I understand that Atlanta GYN & OB, PC does not bill patients for office visits or copays. Payment must be made at the time of the visit.

Initials: _____

I understand that I will be charged a cancellation fee for canceling my appointment less than 24 hours in advance. Failure to show up for an appointment will result in a No Show Fee which must be paid prior to my next appointment.

Initials: _____

I have received a copy of Atlanta GYN & OB, PC's Notice of Privacy Practices. (If you have not received our Privacy Practices Notice, please see Receptionist to receive your copy)

Initials: _____