Tuscarawas County Obstetrics & Gynecology, Inc.

200 Medical Park Dr. Suite B
Dover, Ohio 44622
(330) 343-0890
Fax: (330) 343-0914

Marcel N. Nwizu, M.D., F.A.C.O.G.
Certified American
Board of Obstetrics & Gynecology

Patient Information

Last Name____________________First Name_________________Middle Name_________________

Mailing Address____

City________________________State_______________________Zip_________________________

Home #_____________________Work #_____________________Cell #_______________________

Date of Birth_________________Social Security #_____________Previous/maiden name__________

Marital Status
Please select one of the following: Single___Married___Divorced___Separated___Widowed___

Student Status
Please select one of the following: Full Time___Part Time___Not a student___

Primary Care Physician: ________________________Referring Physician:______________________

Please List Any Medical Conditions or Concerns:____

Related Family or Personal Medical History:____

Patient Employer Information

____Yes, I am able to be contacted at work

Employer Name____

Address____

City______________________State__________________________Zip________________________

Phone #___________________Please select one of the following: Full time___Part time___Military duty___Self employed___Retired___Not employed___

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Emergency Contact/Spouse Information

____ Address is the same as patient

Last Name__________________First Name__________________Middle Name__________________

Mailing Address____

City_______________________State_______________________Zip__________________________

Home #____________________Work #_____________________Cell #________________________

Date of Birth_________________________Social Security #_________________________________

Emergency Contact/Spouse Employer Information

___Yes, I am able to be contacted at work

Employer Name____

Address____

City_____________________State__________________________Zip_________________________

Phone #_____________________Please select one of the following: Full Time ___ Part Time___
Military Duty ___ Self Employed ___ Retired ___ Not Employed___

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Patient Insurance Information

Primary Insurance Company:____

ID #______________________Group #______________________Phone #____________________

Information provided below should be about the person who is the **Carrier** of the Insurance: ___same as patient

Last Name_________________First Name____________________Middle Name________________

Mailing address____

City______________________State________________________Zip________________________

Home #___________________Work #______________________Cell #______________________

Date of Birth_______________Social Security #____

Secondary Insurance Company:____

ID #_____________________Group #______________________Phone #____________________

Information provided below should be about the person who is the **Carrier** of the Insurance: ___same as patient

Last Name________________First Name____________________Middle Name________________

Mailing Address____

City_____________________State________________________Zip________________________

Home #__________________Work #_______________________Cell #______________________

Date of Birth______________Social Security #____

Authorization is hereby given for the release of medical information to the above named insurance carrier for the purpose of payment of charges and claims submitted. Authorization is also given for payment of said charges to the provider listed.

Authorized Signature_______________________________________Date____________________

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Patient Name____Date_____________________________

Allergies____

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Please List **ALL** Medications you are presently taking:
(an example: birth control, vitamins, herbal remedies, etc. . .)

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Financial Policy

We are committed to providing you with the best possible care. We are anxious to help you receive your maximum allowable benefits if you have medical insurance. In order to do this, we need your assistance and your understanding of our FINANCIAL POLICY.

Payment for services is DUE AT THE TIME SERVICES ARE RENDERED, unless payment arrangements have been approved in advance by our office manager. We accept CASH, CHECK, MASTERCARD AND VISA. Returned checks will be subject to a $30.00 NSF FEE. Remember that you are responsible for all auto accident claims. All unpaid WORKER'S COMPENSATION claims will also be the responsibility of the patient.

If there is a DIVORCE involved, please remember that our policy requires that a divorce decree be brought in to keep with your records regarding who is responsible for the billing, if your insurance does not pay. If you have no insurance then the bill will become the responsible parties' and will be due at the time of service. Please feel free to discuss this with our office manager if you have any questions.

We will process your claims to your insurance companies as long as we have a copy of your insurance cards. You also, as the patient, should complete a claim form with your section on it and submit it to your insurance company as soon as possible after your visit. (This should be done for every new diagnosis you have.)

1. Your insurance is a contract between YOU, YOUR EMPLOYER, and the INSURANCE COMPANY. If you disagree with any payment that was denied you need to contact the insurance company and not our office. If it is a mistake on our part please call us.
2. Not ALL services are a covered benefit in all contracts. Please contact your insurance company handbook to see what is covered and what is not covered under your policy.
3. If you have an insurance company that requires a referral form from your primary physician on the plan, then it is up to you to make sure that the referral is authorized before your visit with us. If you do not have referral for the visit then it becomes your RESPONSIBILITY.

We must emphasize that as a provider of medical services, our relationship is with YOU, not your insurance company. While the filing of patient insurance forms is a courtesy that we extend to our patients, all charges are YOUR responsibility from the date service is rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

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Patient Rights and Responsibilities

Welcome to Tuscarawas County Obstetrics & Gynecology Inc. The office respects your rights as an individual. The following information will help you know what your rights and responsibilities are as a patient.

Appointments: All appointments are made in advance. Patients are seen BY APPOINTMENTS ONLY. It is your responsibility to keep or reschedule all appointments. If you are more than 15 minutes late, your appointment will need to be rescheduled.

Emergency Care: Emergency care is only available in the Emergency Room.

Confidentiality: No medical information about you will be given over the phone or in writing to anyone except you, or in the case of a minor, to your legal guardian, without your permission.

Missed Appointments: If you miss three scheduled appointments consecutively, you will receive a letter telling you that you will no longer be a patient of Tuscarawas County Obstetrics & Gynecology, Inc. Please call and reschedule your appointment if you cannot come.

Your Rights:

You have the right:

- To considerate and respectful care
- To obtain answers to any questions about you that are in terms you can understand
- To receive information and explanation about any procedures or treatments prior to them being done, and to know what alternatives if any are available.
- To refuse treatment to the extent permitted by law, and to be told the medical consequences' of this action
- To know the name of your doctor and how to contact him
- To see your bill and have questions about cost answered

The Ohio Legal Right Service is available to answer additional questions you may have concerning patients rights: Ohio Legal Right Service, 8 E. Long Street, Columbus, OH 43215, 1-800-282-9181

Our purpose is to provide the highest quality of health care for you and to provide education to help you maintain a state of well-being. If you have a concern about the care you are receiving, discuss that concern with your doctor.

_____I have read the above rights and responsibilities and understand and accept them.
_____The rights and responsibilities have been read to me and I understand and accept them.

Signature____Date________________________

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Acknowledgment of Release of Medical Information

I, ____authorize Dr. Marcel Nwizu and his medical staff to release any and all of my medical information including; billing information, test results, appointment details and any other pertinent information to the following individuals.

Last Name_______________________First Name_________________________Phone #__________________

Relationship to Patient: Mother___ Father___ Guardian___ Spouse___ Friend___
Other (please specify)____

Last Name_______________________First Name_________________________Phone #__________________

Relationship to Patient: Mother___ Father___ Guardian___ Spouse___ Friend___
Other (please specify)____

Last Name_______________________First Name_________________________Phone #__________________

Relationship to Patient: Mother___ Father___ Guardian___ Spouse___ Friend___
Other (please specify)____

Patient Signature____Date__________________________

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ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

TUSCARAWAS COUNTY OB/GYN INC.

By signing below, I acknowledge that I have received the *Notice of Privacy Practices* from Tuscarawas County Ob/Gyn Inc.

WITNESSES:

X________________________________**X**________________________
Patient Signature **Date**

__________________________________ __________________________
Witness Signature **Date**

Documentation of Failure to Obtain Signed Acknowledgment

On_____________, ______________________presented this Acknowledgment of Receipt
(Date) (Employee's Name)

of Notice of Privacy Practices form to __________________________. The patient refused
(Patient's Name)

to provide a signature when requested.