Advanced GYN Solutions
G. Daniel Robison, MD

Patient Registration

Legal Name (Last, First, Middle): _____

Preferred Name or Nickname: _____ DOB: _____

Sex: ☐ M ☐ F Race: _____ Ethnicity: _____

Primary Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

Insurance Subscriber, if not self:

Legal Name (Last, First, Middle): _____

DOB: _____ Relationship to patient: _____

Address: _____

City/State/Zip code: _____

Primary Phone Number: _____ Type: _____

Secondary Phone Number: _____ Type: _____

Email Address: _____

Can we text you? ☐ Yes ☐ No Can we email you? ☐ Yes ☐ No

Preferred Pharmacy Name and Location: _____

Primary Care Physician: _____

Emergency Contact

Name: _____

Phone Number: _____

Relationship to patient: _____

Advanced GYN Solutions
G. Daniel Robison, MD

Name: _____
DOB: _____

Authorization, Assignment of Benefits, Referral Medical Release, and Request for Treatment:

HIPPA PRIVACY AND RELEASE OF INFORMATION AUTHORIZATION

1. I acknowledge that I have received or been offered a copy of Robison Advanced GYN Solutions, PLLC's HIPPA Policy and Privacy Practices. _____ (initial)
2. I authorize ROBISON ADVANCED GYN SOLUTIONS PLLC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services. I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority. If applicable, Legal Representative sign below: By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form. _____ (initial)

Privacy Instructions

Yes ☐ No ☐ May we discuss details regarding your care, your test results, billing information, or appointment information with someone else other than you? If yes, please list the name and relationship of each individual below.

	Name	Relationship
1.		
2.		
3.		

Yes ☐ No ☐ May we leave detailed messages on your answering machine or voice mail (e.g., test results)? If so, what phone number should we use for this purpose?

Please provide: _____

Advanced GYN Solutions
G. Daniel Robison, MD

Name: _____
DOB: _____

I authorize the release of medical information including complete medical records, test results and billing information to my insurance company and to other medical professionals and medical institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliant resolution. I authorize payment directly to Robison Advanced GYN Solutions, PLLC for all medical and/or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all copayments, deductibles and non-covered services. Overpayments on any Robison Advanced GYN Solutions, PLLC may be applied to your patient balance within the network. Robison Advanced GYN Solutions, PLLC maintains personnel and facilities to assist my physician in providing the medical care and I authorize Robison Advanced GYN Solutions, PLLC personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed procedure and any available alternative methods or treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physician to provide according to recognized standards of medical practice and I acknowledge that Robison Advanced GYN Solutions, PLLC and its personnel are responsible for providing this information. A photocopy of this authorization shall be considered as effective as valid as the original. I acknowledge that a $25 “no show“ fee will be added to my account if I fail to contact Robison Advanced GYN Solutions, PLLC 15 minutes before my appointment in the event that I will not be able to attend said appointment.

_____ _____

Signature of patient/parent or guardian Date

_____

Printed name and relationship if different from patient

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