**Nickel Obstetrics & Gynecology**

**222 North J Street, Suite A**

**Tacoma, Washington 98403**

**(253) 572-4664**

|  |  |
| --- | --- |
| **Date** |  |
| **Home Phone** |  |
| **Cell Phone** |  |
| **Work Phone** |  |
|  |  |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status: (**circle one**) S M W D Other Religious Preference** (optional) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse/Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Person:** (not living at same address)

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #: (**H**)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**C**)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ID NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Relationship to Subscriber (**circle one**) Self Spouse Child Other**

**SECONDARY INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ID NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Relationship to Subscriber (circle one) Self Spouse Child Other**

***SIGNATURE REQUIRED ON THE REVERSE SIDE OF THIS PAGE***

Nickel Obstetrics & Gynecology

Consent & Authorization

**Billing**

I authorize Adam Nickel, DO and Nickel Obstetrics & Gynecology, to furnish all requested information to any insurance company insuring me. I assign to Adam Nickel, DO all insurance payments for medical services performed by him and his staff. Any payments which exceed the amount I owe for medical services are to be refunded. I acknowledge financial responsibility for all charges for services rendered to me***.***

**Insurance**

It is the patient’s responsibility to know if Dr. Nickel is an “in network/preferred provider” with their insurance. The patient is responsible for any fees not covered by their insurance.

**Laboratories**

Nickel Obstetrics & Gynecology sends medical tests to multiple laboratories. It is the patient’s responsibility to verify what labs are in their insurance network, and to notify the staff where the test should be processed, if not the tests will be sent to one of our default labs. Laboratories bill for their own services and are independent entities from Nickel Obstetrics & Gynecology. The patient is financially responsible for all fees associated with their lab charges. You can get a list of labs from the front desk to assist you when verifying your “in network/preferred” labs.

**Informed Consent**

I authorize and allow Adam Nickel, DO, and the staff of Nickel Obstetrics & Gynecology to examine and treat me according to medical standards and practices.

***Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Signature (Patient or Responsible party): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Important Notices**

**HIPAA Notice of Privacy Practices.**

Federal Law requires us to provide you with a HIPAA Notice of Privacy Practices. The Notice is available on our website, NICKELOBGYN.COM. By signing below, you acknowledge that you can access HIPAA Notice of Privacy Practices on our website. Go to NICKELOBGYN.COM and then click on the ”INFORMATION” tab, and click on HIPAA.

**Health Care Directive and Durable Power of Attorney.** We, as do most health care facilities, assume that you would want all needed services, including life sustaining procedures unless you indicate otherwise. Washington State law provides for two documents to help you convey your wishes for treatment if you are not capable of doing so yourself. One is the **Health Care Directive** (or sometimes called a “living will”) and the other is the **Durable Power of Attorney for Health Care.** You should consider both.

**Health Care Directive:** The Health Care Directive allows you to specify in advance how you want decisions to be made about life-sustaining treatment if you have a terminal illness or disease. If you desire to sign a Health Care Directive you must then also specify whether you want nutrition (food) and hydration (water) withheld or administered to you.

**Durable Power of Attorney for Health Care:** The Durable Power of Attorney for Health Care is a legal document in which you can name a person as your health care agent. This person is given the power to make medical decisions for you if you are unable to make them for yourself.

Both of these documents have significant legal consequences and therefore we encourage you to consult with your attorney regarding the advisability of entering into either or both of them. Copies of these documents are available from most hospitals, the Washington State Medical Association and your attorney.

***Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Signature (Patient or Responsible party): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***