BERKSHIRE OB/GYN ASSOCIATES, P.C.
777 NORTH STREET, PITTSFIELD, MA 01201
413-499-8570

PLEASE FILL OUT BOTH SIDES OF THIS FORM TO THE BEST OF YOUR ABILITY

Name:	Maiden Name:
DOB:	SS#
STREET ADDRESS: _____ MAILING ADDRESS:	City, _____ State, Zip
Phone: Home # ( ) _____ Work # ( ) _____ Occupation _____ Cell # ( ) _____ Email address: _____ Employer	
If Under 18 Parent/Guardian:	Phone #:
Spouse's Name:	Work Phone:
Emergency Contact: Name: _____ Address: _____	Phone: _____ Relation: _____
Nearest Relative not living with you _____	Phone: _____
Are you currently employed? ☐Yes ☐No Are you covered under an employer or union health plan? ☐Yes ☐No Did you sustain an injury while at work? ☐Yes ☐No Are your injuries accident related? ☐Yes ☐No Is your spouse or other family member currently employed? ☐Yes ☐No	
I will be paying today by cash: _____ check: _____ credit card: _____	(for services rendered today or any past due balances)
INSURANCE INFORMATION	☐ I DO NOT HAVE MEDICAL COVERAGE
Insurance Company:	Phone #:
ID Number:	Group #:
Subscriber Name:	Employer:
DOB:	Relation:
SECONDARY INSURANCE INFORMATION	☐ I DO NOT HAVE SECONDARY MEDICAL COVERAGE
Insurance Company:	Phone #:
ID Number:	Group #:
Subscriber Name:	Employer:
DOB:	Relation:

AUTHORIZATION/ASSIGNMENT OF INSURANCES AND INFORMATION

Payment is requested when service is rendered. OB patients without insurance must have their estimated fee paid in full by 28 weeks gestation.

I hereby assign benefits from Medicare/Medigap/Medicaid/my Health Insurance(s) to Berkshire OB/GYN, Assoc., PC Drs. A. Beckwith, R. Benner, H. Kantor, C. Service, M. Shreefter and employed Mid-Level Providers for all services billed to Medicare/Medigap/Medicaid/my Health Insurance(s) for which I have not paid in full. A copy of this agreement shall be as valid as an original.

I understand I will be financially responsible for any services considered to be non-covered by Medicare/ Medigap/Medicaid/my Health Insurance.

I authorize the release of any medical information necessary to process my claims, and for Utilization Review/ Chart Audits that may be required under the guidelines of my insurance company.

It is understood and agreed that the physicians of Berkshire OB/GYN Assoc., PC have the right to designate which doctor(s) will perform medical services requested by the undersigned patient.

Date _____ Signature _____

A photocopy of these assignments shall be valid as the original. A $25.00 service fee will be charged if you do not pay your co-pay at time of visit as stated in your insurance contract.

PLEASE TURN FORM OVER TO COMPLETE THIS FORM ⟹