

Four Seasons Ob/Gyn, MD, PA Patient
Karen Feinstein, MD; Nancy Rector-Finney, MD

Patient Information Form

Referred by: _____ Email address: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Social Security No. _____

Mailing Address: _____ Apt/Ste: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work): _____

(Cell) : _____ Marital Status: _____

Driver License No. _____ State: _____

Employer: _____ Occupation: _____

Emergency Contact: 1) Name _____ Phone No. _____

Emergency Contact: 2) Name _____ Phone No. _____

Primary Insurance:

Insurance Co. _____ ID#: _____

Group #: _____ Insured's name: _____

Insured's Employer: _____ Insured's DOB: _____

Insured's Social Security No. _____

Insured's relationship to the patient: _____

Secondary Insurance:

Insurance Co. _____ ID#: _____

Group #: _____ Insured's name: _____

Insured's Employer: _____ Insured's DOB: _____

Insured's Social Security No. _____

Insured's relationship to the patient: _____

- **Please try to give at least 24 hours notice if you must cancel or reschedule your appointments so that we may utilize that time slot for another patient.**
- **You may call our office 24 hours a day at (210) 593-0700 for emergencies and for appointment cancellation. No appointments will be rescheduled after regular office hours.**
- **You may be charged \$25.00 for missed appointments if you fail to cancel the appointment in advance.**
- **Switching between doctors within this practice is not permitted.**
- I hereby give authorization for payment of medical insurance benefits to be made directly to the doctor indicated at the top of this form, and any assisting physicians, for services rendered.
- I understand that I am financially responsible for all charges whether or not they are covered by insurance.
- I understand that all charges are due and payable when services are rendered, unless other payment arrangements are made with the physicians. I agree to pay finance charges, at the rate of one and one-half percent (1 ½ %) per month, on any amount due on my account that is 30 days past due.
- In the event of default, I agree to pay all costs of collection and reasonable attorney's fees.
- I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
- I further agree that a photocopy of this agreement shall be as valid as the original.

Thank you for your cooperation.

Signature: _____ Date: _____