Cindi Denbow CNM, ARNP
296 Bayshore Drive
Niceville, FL 32578
(850) 279-6778 office
(850) 254-1922 fax

Gyn Registration

Client

Name:		Today's Date:	Email Address:	
Street Address:		City	State:	Zip:
Home Phone:	Work Phone:	Cell:	Birth Date:	Your Age:
Marital Status S ❑ M ❑ D ❑ W ❑	Race: Caucasian☐ African American☐ Asian☐ Other☐ _____		Social Security#:	
Employer's Name:				
Employer's Address:				
May we leave messages at your home? Yes / No If No, please provide an alternate number:				

Primary Insurance

Name of Insured:		Identification Number:	
Name of Insurance Company:	Phone:	Authorization Number:	
Insurance Address:	City:	State:	Zip:

Please Tell us How You Heard About Us?

Emergency Contact Person: **Relationship:** **Phone:**

Consent For Treatment … Authorization for Assignment of Benefits and Information Release

Participating Insurance

I hereby give consent to Gentle Birth Options, LLC to provide whatever treatment she may deem necessary to the client above. I hereby request payment of authorized benefits and /or any insurance benefits to be paid directly to Gentle Birth Options, LLC for any services furnished to the client by Gentle Birth Options, LLC. I authorize Gentle Birth Options, LLC and staff to release to my insurance carrier and its agents any information concerning healthcare, advice, treatment provided to the client, needed to determine these benefits or the benefits payable for related services. I understand I am responsible for charges not covered by the insurance policy (excluding workman's compensation cases), and should it become necessary to collect these charges through an attorney or other collection process, I shall be responsible for all costs.

_____ _____
Signature of client/responsible party Date

Private Pay

I hereby give consent to Gentle Birth Options, LLC to provide whatever treatment deemed necessary to the client above. I understand that I am responsible for charges incurred for services and that payment is due at the time of service. It is my responsibility to bill my insurance company for these fees unless other arrangements have been made. I understand I am responsible for charges and should it become necessary to collect these charges through an attorney or other collection process, I shall be responsible for all costs. I authorize Gentle Birth Options, LLC and staff to release to my insurance carrier and it's agents any information concerning healthcare, advice, treatment provided to the client, needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature of client/responsible party Date