

Suzanne K. Hentz, M.D.
GYNECOLOGY

Fellow of the
American College of
Obstetrics and Gynecology

Board Certified in
Obstetrics
and Gynecology

Thank you for your interest in becoming a patient of Dr. Suzanne Hentz. Our office is located at 4815 Oleander Drive on the second floor of the building. If you need directions, please call (910) 452-1133.

Our office hours are Monday through Friday from 8:30-12:00 and 1:00-4:00.

Dr. Hentz participates with **Blue Cross Blue Shield (all plans EXCEPT Blue Value), Cigna, United Healthcare, Aetna, Medcost Preferred, and Medicare**. If you have a commercial plan other than the ones listed above, you will be responsible for payment in full at the time of service. We will be happy to file a claim as a courtesy to help with your reimbursement if applicable. We do NOT participate with Medicaid or Tri-Care. If you have **Medicaid you can not** be seen in this practice at this time.

I have enclosed a packet for you to fill out and mail/fax back to (910) 452-5829 to our office prior to your appointment if you can, otherwise please bring it with you to your appointment filled out. We will also need a copy of the front and back of your insurance card to attempt to verify your benefits/coverage. We do our best to determine what the insurance will pay, but it is ultimately your responsibility to know your health care benefits.

If you need to reschedule your appointment, we ask for 24 hours notice please. Thank you again for your interest in our office and we look forward to meeting all of your gynecological needs.

Full Name: _____
(as it appears on ins card)

Nickname: _____

Street Address: _____

City, State, Zip: _____

Mailing Address: _____
(if different from street address)

Home phone: _____

Work phone: _____

Cell phone: _____

Emergency contact: _____
(include phone number)

Date of Birth: _____

Social Security #: _____

Drivers License #: _____
(include state)

Employer: (FT or PT) _____

Student: (FT or PT) _____

Marital Status: _____

Insurance Information should be completed in full AND include a copy of your insurance card

Primary Cardholder: _____

Primary Date of Birth: _____

Primary Social Security #: _____

Primary Address (if different from patient): _____

Primary Employer: _____

Primary Relationship to patient: _____

OFFICE VISIT PAYMENT POLICY

1. Some Insurances have special limited benefits that only pay for WELLNESS / PREVENTIVE / ROUTINE / WELL WOMAN visits. Do you want to apply your charges today to your WELLNESS / PREVENTIVE / ROUTINE / WELL WOMAN benefits? YES _____ NO _____

Once an insurance claim has been submitted to the insurance company, the way that it is coded CANNOT be changed later. If any medical problems are addressed at your visit, diagnosis codes and a co-payment may apply.

2. How will you be paying for your visit today?

_____ Cash _____ Credit/Debit Card _____ Personal Check

Driver's License # _____

*Required with Check payment. Must match name on Check.

FULL PAYMENT IS REQUIRED AT THE TIME OF SERVICE: Please tell the Receptionist in advance if there is a special reason why this may be difficult for you so that we can make special arrangements. We accept cash, personal checks, MasterCard, Visa, Discover and American Express. Please note that **Finance Charges** may be assessed on any unpaid patient balances after 30 days. **Finance Charges** will be computed at an annual percentage rate of 18% (periodic monthly rate of 1½ %).

COMMERCIAL INSURANCE: Full payment for service is required at the time of the office visit, according to the **Office Visit Payment Policy**. As a courtesy to you, we file all insurance claims for your office visits at no additional charge.

HMO/PPO INSURANCE: We are participating providers with **Blue Cross Blue Shield, United HealthCare, MedCost, Aetna, Cigna** and **Medicare** Insurance Plans. Patients must pay the full amount of their co-payment at each office visit. We do NOT participate with **MEDICAID, CHAMPUS/TRICARE, and BLUEVALUE BCBS.**

INSURANCE AND PAYMENT AUTHORIZATION

I hereby authorize payment of medical benefits from my insurance plan directly to Suzanne Hentz, MD, Gynecology, PC for medical services. I realize that I am responsible for payment of non-covered services. I hereby authorize Suzanne Hentz, MD, Gynecology, PC to release any medical information that is necessary to process my insurance claims.

I have read, and agree to comply with the payment policy and insurance authorization described above.

X

Signed _____

Date _____

PATIENT HISTORY FOR: _____

(Name)

Drug Allergies: _____

Total no. of pregnancies: _____

Number of miscarriages: _____

Number of abortions: _____

Pregnancy History

| Year | Term or Premature | Type of Delivery (vaginal or C-section) | Baby's Weight | Complications |
|------|-------------------|--|---------------|---------------|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

Your Medical History

- ___ Rheumatic Fever
- ___ High Blood Pressure
- ___ Kidney Disease
- ___ Heart Disease
- ___ Lung Disease
- ___ Gastro-Intestinal Disease
- ___ Neurologic/Psychiatric Disorder
- ___ Migraine Headache
- ___ Endocrine Disorder (Diabetes, thyroid disorder, etc...)
- ___ Substance Abuse History
- ___ Sexually Transmitted Diseases
(Herpes, gonorrhea, chlamydia, genital warts, syphilis)
- ___ Other
- ___ Other
- ___ Other

Family Medical History

- ___ High Blood Pressure
- ___ Heart Disease
- ___ Diabetes
- ___ Kidney Disease
- ___ Cancer (Breast, Uterus, Cervix, Ovary, Colon, etc...)
- ___ Other
- ___ Other

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received or have been offered a current copy of
Patient Name
Dr. Suzanne Hentz's "Notice of Privacy Practices".

Signature of Patient

Date

You have my permission to speak with the following person(s) about my medical health,
including confidential information such as pregnancy or sexually transmitted diseases.

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____