Patient Registration Information – Women's Health Specialists

Who are you scheduled to see today? ______________________________

Who is your Primary Care Provider? ______________________________

Name of physician who referred you to WHS?______________________________

Name:______________________________ Date of Birth:______________________ Sex: F ( ) M ( )
Last First MI

Address:____
Street City State Zip Code

Home Phone:____________________Cell Phone:____________________ SSN:____________________

Marital Status:______________ Race__________ Hispanic Y / N Preferred Language:______________

Email address:______________________________ May we contact you via email? Y / N

Have you been treated by these physicians before? Y / N Under What Name? ______________________________

Employer:______________________________ Work Phone:____________________

Emergency contact:____
Name and Phone Number Relationship to Patient

Insurance Information – Please give your card to the receptionist for copying

Primary Insurance:______________________________ ID #:____________________ Group #:______________

Policyholder's Name:______________________________ Date of Birth: ______________________________

Secondary Insurance:______________________________ ID #:____________________ Group #:______________

Policyholder's Name:______________________________ Date of Birth: ______________________________

Pharmacy Information

Pharmacy Name: ______________________________ Pharmacy Phone: ______________________________

Communication Preference: Phone__________ Text__________ Email through portal______________

Parent / Guardian or Person Responsible for Paying Bill

Name:______________________________ DOB: ______________ Relationship to Patient: ______________
Last First MI

Address:____
Street City State Zip Code

Home Phone:____________________ Cell Phone: ____________________SSN ____________________

To the best of my knowledge the above information is complete and correct. I understand it is my responsibility to inform Women's Health Specialists and its staff if I or my child / ward has a change in health, insurance coverage or contact information.

Signature: ______________________________ Date: ____________________
Patient, Parent or Guardian

How did you hear about us?

( ) I was a former patient
( ) Family / Friend______________________________
( ) Physician ______________________________
( ) Employer ______________________________
( ) ZocDoc ( ) Website
( ) Insurance______________________________
( ) Patient ______________________________
( ) Other:______________________________

Advance Directive

Do you have an Advance Directive? Y / N

________Initials

CONSENT FOR CARE / AUTHORIZATIONS / UNDERSTANDINGS

- I hereby give my consent for treatment at Women's Health Specialists.
- I hereby authorize payment to Women's Health Specialists for services rendered to me or my dependents.
  I also authorize this office to release any information necessary to expedite insurance claims.
- I request lifetime authorization that payment of authorized Medicare benefits be made either to me or on my behalf to Women's Health Specialists for services furnished me by that provider. I also authorize any holder of medical information about me to release to the Center for Medicare / Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.
- I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
- I authorize fax transmittal of my records, if necessary.
- I understand that if I do not inform WHS of special requirements in my insurance contract such as **lab work, screening / preventative care / hospitalization, and /or out-patient procedures** that are not covered, or must go to a **specific location**, or **the need for a referral** from my primary care physician, I will be billed directly for those charges. I must inform the office at **EACH** visit. I understand that ultimately these charges are my responsibility.
- I understand there will be a $50 charge, per instance, for obtaining prior authorizations required by your insurance company for medications or completion of forms such as FMLA or disability.
- **I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.**
- I understand payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- **I acknowledge full responsibility for services rendered by Women's Health Specialists.**
- I understand that a fee of $30 will be charged for any returned check.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Signature: ______________________________ ______________________ ______________________
Patient, Parent or Guardian | Relationship to Patient | Date

Please circle indicating your consent:

Authorization to Leave Message

Yes No I hereby authorize Women's Health Specialists to leave a message regarding appointments or tests at my residence or cell phone.

Authorization to send appt reminders or other alerts via text, voice or email message

Yes No I hereby authorize Women's Health Specialists to leave a message regarding appointment reminders via text, voice or email reminders. It is my responsibility to provide the clinic with the most up to date contact information.

Photo Consent

Yes No I hereby authorize Women's Health Specialists to take my picture for my electronic medical record.

RX Consent

Yes No I hereby authorize Women's Health Specialists to electronically access my prescription history from SureScripts (a prescription database compiling all prescription history).

Signature: ______________________________ ______________________ ______________________
Patient, Parent or Guardian | Relationship to Patient | Date

Please provide a list of anyone besides yourself who has permission to receive information regarding any of the contents of your medical records. This can include any family member or other healthcare provider. We will not be able to release information to any person not listed below.

Name: ______________________ Relationship to Patient: ______________ Phone Number: ______________

Name: ______________________ Relationship to Patient: ______________ Phone Number: ______________

Name: ______________________ Relationship to Patient: ______________ Phone Number: ______________

By signing below, I understand that I may revoke this authorization at any time by notifying Women's Health Specialists in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

Signature: ______________________________ ______________________ ______________________
Patient, Parent or Guardian | Relationship to Patient | Date