

Women's Wellness Center Registration Form

REMINDER: INSURANCE CARD AND PHOTO ID ARE REQUIRED FOR ALL NEW PATIENTS

Patient Information:

Name: (last) _____ (first) _____ (middle initial) _____

Date of Birth: _____ Marital Status: __S __M __D __W SSN: _____

Street Address: _____ City/State: _____ Zip: _____

Circle preferred phone: Home: (____) _____ Work: (____) _____ Cell: (____) _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ DOB: _____ Phone: _____

May we email/text appointment reminders? __Yes, Text __Yes, Email: _____

Responsible Party (if different than patient):

Name: (last) _____ (first) _____ Date of Birth: _____

Gender: __Male __Female SSN: _____ Relationship: _____

Street Address: _____ City/State: _____ Zip: _____

Circle preferred phone: Home: (____) _____ Work: (____) _____ Cell: (____) _____

Employer: _____ Occupation: _____

Consent to Treatment, Insurance Authorization, and Financial Responsibility:

I hereby give my permission for WOMEN'S WELLNESS CENTER to provide medical treatment.

I allow the Practice to file for insurance benefits to pay for the care I receive.

I understand that:

The Practice will have to send my medical record information to my insurance company.

I must pay my share of the costs.

I must pay for the cost of medical services if my insurance does not pay or I do not have insurance.

I have the right to refuse any procedure or treatment.

I have the right to discuss all medical treatments with my provider.

Signature of Patient or Responsible Party: _____ Date: _____

Statement of Notice of Privacy Practices (HIPAA):

I hereby acknowledge that I have had an opportunity to view Women's Wellness Center's Privacy Practices.

Signature of Patient or Responsible Party: _____ Date: _____