Women's Wellness Center • Columbia Hormone Health

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 (WWC)/COLUMBIA HORMONE HEALTH (CHH) (WWC) to provide medical treatment.
I allow WWC/CHH to file for insurance benefits to pay for the care I receive.
I understand that:

- To bill insurance (if applicable), WWC/CHH will send my medical 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: _____