# *PrimeGYN Women's Center*

PATIENT REGISTRATION

| PATIENT INFORMATION | | |
|---|---|---|
| Date of Birth | Gender: Race: | Age: |
| First Name: | | Pharmacy Name/Number: |
| Last Name: | | Social Security #: |
| Address: | | City, State, Zip: |
| Email:<br>PCP Name and Phone: | | Mobile Phone:<br>Work Phone:<br>Home Phone: |

| RESPONSIBLE PARTY | | |
|---|---|---|
| | Patient Relationship to Guarantor: | |
| Last Name: | | Gender: Marital Status: |
| First Name: | | Date of Birth: |
| Address: | | Social Security #: |
| City, State, Zip: | | Home Phone: |

| INSURANCE INFORMATION | | |
|---|---|---|
| **Primary Insurance:** | | Policy Subscriber Name: |
| Address: | | Insured Policy ID: |
| City, State, Zip: | | Group Number: |
| Plan Phone: | | Date of Birth: |
| | | Patient Relationship to Subscriber: |
| **Second Insurance:** | | Policy Subscriber Name: |
| Address: | | Insured Policy ID: |
| City, State, Zip: | | Group Number: |
| Plan Phone: | | Date of Birth: |
| Effective Dates: | | Patient Relationship to Subscriber: |

| PARENT/LEGAL GUARDIAN AND EMERGENCY CONTACT INFORMATION | |
|---|---|
| Parent/Legal Guardian Name: | **Emergency Contact:** |
| Address: | Address:<br>Patient relationship to Contact: |
| Parent Home Phone: | Contact Home Phone: |
| Parent Work Phone: | Contact Work Phone: |

## MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

I hereby authorize PrimeGYN Women's Center to furnish the insured's insurance company all information which said insurance company may request concerning my present illness. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges. I hereby authorize PrimeGYN Women's Center to provide such medical services, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

**x**_____ Date:_____

Signature

- **Prescriptions.** All prescription refill requests should be called in to your pharmacy. Your pharmacy will then contact the office if authorization is needed. Your refill requests will be handled by the practice within 24-48 hours after your pharmacy's request is received and during business hours only.

- **Test Results.** Should you have any laboratory work or other diagnostic testing done through our practice, you will be notified of the results as soon as they are available. All results must first be reviewed by the provider. After review, you will be notified.

- **Forms Completion.** Completion of forms for insurance purposes, such as application for insurance coverage, disability, or FMLA leave, will be billed to the patient at a fee of $25 or $50 for expedited forms.

- **Insurance and Payment Policies**

  - **Proof of Insurance. We ask that you present your insurance card to us at every visit.** If you fail to provide us with the correct insurance information at each visit, you may be responsible for payment for all services provided.
    - Your health insurance contract is between you and your insurance company. Knowing your insurance benefits is your responsibility. Any questions or complaints regarding your coverage should be directed to your insurance company.
    - We are contracted with most insurance plans. If you are not insured by a plan we are contracted with, payment in full is expected at the time of service.

  - **Co-Payments/Deductibles.** Your insurance company requires us to collect co-payments and/or deductibles **at the time of service**.

  - **Non-covered Services.** Please be aware that some or all the services you receive may be non-covered or not considered medically necessary by your insurer. You must pay for these services in full.

  - **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help you get your claim(s) paid. Your insurance company may need you to supply certain information directly. It is your responsibility to promptly comply with their request.

  - In the event our filed claim is not processed by your insurance company, you the patient, parent, or guardian assume financial responsibility for the full remaining balance.

  - **Account Balances.**
    - Account balances are to be paid in full unless acceptable payment arrangements have been established with our billing office.
    - Payments made to satisfy account balance(s) will always be applied to oldest date(s) of service.
    - **Outside collection action WILL result in a 20% collection fee in addition to your account balance in which you will be responsible. Additional fees can also include, but not limited to, collection fees, attorney fees, and court fees.**

  - **Notification of Health Insurance Changes.** If your health plan has changed, you are responsible for notifying us as soon as possible. If we are not aware of the change(s), you could be held liable for the full cost of your visit by your health plan.

  - **Returned Check Fee.** A $35 Returned Check Fee will be assessed for checks that are returned to us by your financial institution for insufficient funds.

  - **Missed Appointments/Cancellations.** A $25 Missed Appointment fee will be assessed for routine appointments not cancelled or rescheduled with a minimum of **24 hours advance notice.** This fee will be your responsibility and billed directly to you. A $75 fee will be assessed to ALL missed procedure appointments.

I have read and understand the office policies and agree to abide by their guidelines:

_____ _____ ____/____/____

Signature of Patient or Responsible Party Print Name Date