PATIENT REGISTRATION – Información del Paciente

Date:_____

First Name:_____ **Middle Name**: _____ **Last Name**:_____
Primer Nombre Segundo Nombre Apellido

Date of Birth: _____ **SS#**_____ **Email:**_____
Fecha de nacimiento

Phone Number: (_____)_____ **Cell Phone: (_____)**_____ **Work Phone:(_____)**_____
Teléfono de hogar Teléfono celular Teléfono de Trabajo

Home Address:_____**Apt #** _____**City:**_____ **State:** _____ **Zip Code:**_____
Dirección Ciudad Estado Código Postal

Referring Physician:_____ **How did you hear from us:**_____
Doctor que la refirió: Como supo de nosotros?

Marital Status: **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Race:**_____**Ethnicity**_____
Estado Civil Casada Soltera Divorciada Viuda

Check one: **Employed** ☐ **Retired** ☐ **Full Time Student** ☐ **Other:**_____
Marque Uno Empleada Retirada Estudiante tiempo complete Otro

Employer:_____ **Occupation:**_____
Empleador

INSURANCE INFORMATION - Información de Seguro

Insurance Company:_____
Compañía de Seguro

Commercial ☐ **Medicaid** ☐ **Medicare** ☐ **Other** _____

Insured Card Holder's Name: _____ **Relationship:**_____
Nombre del Asegurado Relación

Policy #_____ **Group #** _____ **Phone:(_____)**_____
Número de Póliza Número de Grupo Teléfono

EMERGENCY CONTACT – Contacto de Emergencia

First Name:_____ **Middle Name**:_____ Cell Phone(_____)_____
Primer Nombre Segundo Nombre Teléfono Celular

Last Name:_____Relationship:_____
Apellido Relacion

SPOUSE /GUARANTOR/RESPONSIBLE PARTY – Esposo/Persona Responsable

First Name:_____ **Last Name**: _____ **Date of Birth**: _____
Primer Nombre Segundo Nombre Fecha de Nacimiento

Relationship:_____ **SS#** _____
Relación Numero de seguro social

Phone Number: (_____)_____ **Cell Phone: (_____)**_____ **Work Phone:(_____)**_____
Teléfono de hogar Teléfono celular Teléfono de Trabajo

PHARMACY INFORMATION

Pharmacy Name: _____ **Phone :(_____)**_____ **FAX:(_____)**_____

Address: _____ **City:**_____ **State:**_____ **Zip code:**_____
Dirección Ciudad Estado Código Postal

FEES AND INSURANCE INFORMATION

We have elected not to accept insurance for services rendered in the office. All fees are payable at the time services are rendered. We accept most major credit cards. Your insurance may be able to be used for laboratory tests, imaging studies, and medications. We can also provide a superbill that you can submit directly to your insurance carrier and you MAY be eligible for direct reimbursement from them.

We have elected not to carry Medical Mapractice insurance or otherwise demonstrate financial resposiility. However, we agree to satisfy any adverse judgements up to the minimun amounts pursuant to North Carolina Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to North Carolina Law.

_____ _____

PATIENT'S /GUARANTOR'S SIGNATURE DATE

Women's Health
OF THE HIGH COUNTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_____ have received a copy of this office's Notice of Privacy Practices.

Patient's Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other: _____

Dear Patient,

Under North Carolina law, physicians are generally required to either carry medical malpractice insurance or demonstrate financial responsibility to cover potential claims for medical malpractice. **I HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under North Carolina Law under certain conditions. North Carolina law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to North Carolina Law.

This document must be signed before you initiate or continue treatment under my care.

Thank you.

Jonathan D. Bratter, DO

I,_____have read this document and acknowledge and understand its contents.

Patient's Signature:_____Date:_____

Witness' Signature _____