Women First PC

PATIENT REGISTRATION FORM

Account_____ Date_____

Patient Name_____
Last *First* *Middle* *Maiden*

DOB_____ Age_____ SS#_____ Marital Status S M D Separated

Permanent Address
(Not PO Box)_____
Street *City* *State* *Zip*

Mailing Address (if different)_____

Home Phone_____Cell Phone_____Work Phone_____

Pharmacy_____

Email Address_____

Place of Employment or School_____

Occupation_____

Family Physician_____ Referred by_____

Last Menstrual Period_____ Hysterectomy: Yes No Reason for Visit_____

Spouse Name_____ DOB_____ SS#_____

Spouse Place of Employment_____

Insurance Cardholder's Name_____DOB_____Employer_____

Emergency Contact Info (other than significant other)_____

Phone Number_____ Relationship to Patient_____

If a minor, please fill in responsible part information below:

Responsible Party_____ Relationship_____

Address if different from above

_____
_____

Place of Employment

_____
_____

Guarantor SS#_____

AUTHORIZATION TO TREAT MINOR

I authorize the physicians of Women First PC to treat and prescribe medications to:

_____ _____
Minor Child Relationship to Minor

_____ _____
Signature Date

Authorization SS# _____

Please present insurance card to receptionist

CONCERNING INSURANCE

I hereby authorize **Women First PC** to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or, in the case of Medicare Part B benefits to the social security administration and health care financing administration.) A copy of this authorization may be used in place of the original. This authorization may be revoked by me or my insurance carrier at any time in writing.

_____ _____

Signature of Patient, Insured, or Beneficiary *Date*

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to **Women First PC** for services rendered. I further authorize the release of any information needed to process my insurance claims(s). A copy of this authorization may be used in place of the original.

_____ _____

Signature of Patient, Insured, or Beneficiary *Date*

FINANCIAL RESPONSIBILITIES

In the event my unpaid account must be turned over for collection, I understand I will be responsible to pay all reasonable costs including 40% of all collection fees and any attorney's fee(s).

_____ _____

Signature of Patient, Insured, or Beneficiary *Date*

LABORATORY FEES

Medicare, Medicaid, Blue Shield, and other certain insurance companies require you to be informed in advance that there may be certain laboratory procedures which may not be covered because the carrier may determine that the service is not "reasonable and/or necessary". It must be emphasized that in your physician's professional judgement these services are needed in order to render high quality medical care to you. However, in order for you to make an informed decision, you are advised that based on insurance guidelines, it is possible that your carrier may deny certain procedures.

By signing the statement, you are agreeing to pay for laboratory tests, even if your carrier determines that according to its guidelines the services are not "reasonable and/or necessary".

_____ _____

Signature of Patient, Insured, or Beneficiary *Date*

Women First PC

Financial Policy

Insurance:
As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you. It is your responsibility to know and to obtain the proper documents if your insurer requires a referral for your appointment. Failure to follow through with the referral order will move the entire bill to patient responsibility.

Financial Arrangements:
Because we realize that every person's financial situation is different, we provide a variety of payment options. For your convenience, we accept all major credit cards, Care Credit and checks (returned checks will be subject to a $35 returned check fee). If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment.

Appointments/Cancellations:
We gladly reserve appointment times for you and appreciate that you have chosen Women First for your care. We strive to maintain on time as medical emergencies allow. Late arrivals will be asked to reschedule to the next available appointment time. As a courtesy, our automated system will remind you of your appointment by calling and/or text/emailing you 7 and 4 days prior to your scheduled date and time. If our system cannot speak to you directly, it will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. We reserve the right to charge $35 established regular appointments/$75 for new patient appointments and for office procedures cancelled or broken without advance notice of 24 hours. We charge a $150 cancellation fee for regular surgery cancelled without providing us notice 5 business days prior to the surgery

Patient/Parent/Guardian Responsibility:

- I understand that whoever accompanies my child to their appointment has authorization to consent to medical care as needed, and is responsible for payment of medical services.

____ Initial _____Date

- I acknowledge my responsibility for payment of all medical services provided by Women First in accordance with the practice's fees and terms.
- In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.
- At the initial visit you may sign our consent for minor treatment form that allows us to render care at follow up visits without the presence of a parent or guardian. Under Virginia Law a minor has the right to medical privacy when the care rendered pertains to discussion, testing and treatment of STDs and contraception. We may not discuss any of these results with the parent without written consent of the minor signed in our office.

Late Fees:
I understand that my account becomes delinquent if not paid within 30 days after billing and the unpaid balance becomes subject to a monthly finance charge of 1.5%(18% APR) or $35, whichever is greater. Any further delinquency will warrant the balance and any administrative fees being assigned to a collection agency.

Assignment and Release:
I authorize payment to be made directly to Women First PC by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

Credit Card on File Policy:
Women First is committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file with our office. Merchant Center (TSYS) will store your card number in a secure, compliant location for payment plans and through TSYS for incidental charges. For security reasons only the last four digits will be visible to our staff. Credit cards on file will be used to pay copays when you are seen in our office, including account balances, after your insurance processes your claim.

If we do not receive payment for the amount listed on your statement within 13 days, we will run the credit card on file for the full amount owed. If your payment is declined, we will call you. If our reminder call is not returned within one week, a $35 declined payment fee will be applied and another statement will be mailed. Your account becomes delinquent if not paid within 30 days after the date of the original statement. The unpaid balance will be subject to a finance charge of 1.5% (18% APR) or $35, whichever is greater. Further delinquency will be subject to collections with additional finance fees.

I give Women First permission to charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion.

____ Initial _____Date

Patient Consent to Financial Policy/ HIPAA

Notice of Privacy Practices Written Agreement:

I have read a copy of Women First's Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request.

Name (please print):_____ Date: _____

Signature of Responsible Party (Guarantor): _____

Relationship to Patient(s) (please check): ___ Self ___Other: _____

Witness Signature:_____

Note: The patient (or guarantor) must sign this sheet and present valid photo identification before the patient can be seen.
This is for your protection and to prevent fraud.

Women First complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

____ Initial _____Date