OB-GYN Women Physicians Assoc., Inc.

PATIENT REGISTRATION

Account number _____

PATIENT

Name _____ Date _____

Address _____

City _____ State _____ ZIP _____

Date of birth _____ Age _____ Soc. Sec. # _____

Home phone # _____ Medicare # _____ DL # _____ State _____

Work phone # _____ Cell phone # _____ Fax # _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employment status: ☐ Full time ☐ Part time School: ☐ Full time ☐ Part time ☐ Retired

Name of spouse/responsible party _____

Date of birth _____ ☐ Male ☐ Female

His/her employer _____

Employer's address _____

City _____ State _____ ZIP _____

Occupation _____ Work phone _____ Cell _____

PRIMARY INSURANCE

Do you have insurance through your employer? ☐ Yes ☐ No

Insurance co. name _____ ☐ PPO ☐ HMO ☐ Other _____

Insurance co. address _____

City _____ State _____ ZIP _____

ID/Soc. Sec. # _____ Group # _____ Eff. Date _____

Employer _____

Employer's address _____

City _____ State _____ ZIP _____

Occupation _____ Work phone _____ Cell _____

SECONDARY INSURANCE

Do you have insurance through your spouse/responsible party? ☐ Yes ☐ No

If Yes, insurance co. _____ ☐ PPO ☐ HMO ☐ Other _____

Insurance co. address _____

City _____ State _____ ZIP _____

ID/Soc. Sec. # _____ Group # _____ Eff. Date _____

Relationship to patient: ☐ Spouse ☐ Father ☐ Mother ☐ Other

Employment status: ☐ Full time ☐ Part time School: ☐ Full time ☐ Part time ☐ Retired

Primary care physician _____ Phone # _____

Referred by? _____

Notify in case of emergency: ☐ Friend ☐ Relative Home Phone: _____

Work Phone: _____

_____ Cell Phone: _____

Acknowledgments/Disclaimers/Assigment of Benefits

Our office makes every effort to maximize insurance payments. However, please be advised that certification of visits and procedures does not guarantee coverage by your particular plan. In addition, most insurance companies will not pre-determine or guarantee the dollar amount of benefits they will pay until **after** a procedure is done. Therefore, all fees for services rendered, as well as co-payments, deductibles, or fees not covered by your insurance plan are ultimately the responsibility of the patient, or in the case of a minor the financially responsible party. We do not assume responsibility for any errors or omissions in the pre-certification process or any benefits unpaid by your insurance company.

For these reasons, we strongly advise you to become familiar with your insurance plan in order to know and follow the specific guidelines for your particular contract.

I understand that the clinician seeing me may not be a contracted provider and I accept financial responsibility regardless.

I further agree to pay any charges unpaid for any reason.

I have read and understand the above and agree to the terms stated.

I authorize the release of any medical information necessary to process any insurance claim and request payment of insurance benefits to OB/GYN Women Physicians Assoc. Inc., DIRECTLY.

_____ _____

Signature (insured or authorized person) **Date**

If you cannot keep an appointment, you must give us 24 hours notice. If you miss your appointment and do not give us notice and we are unable to fill it, our office reserves the right to charge a missed appointment fee of $25.