REGISTRATION

Patient Information

Date:	Home Phone ( )	Cell ( )
Last Name:	First Name:	Middle:
Social Security #	Driver's License #:	Date of Birth:
Street Address	E-Mail Address:	
City:	State	Zip Code:
Sex: Male or Female	◊ Married ◊ Widowed ◊ Single ◊ Minor ◊ Separated ◊ Divorced ◊ Partnered for ____ years	
Employer Name/School Name:		
Employer/School Address:		
Occupation:	Business Phone #:	

Responsible Party (Guarantor) Information

Last Name:	First Name:	Middle:
Social Security #	Driver's License #:	Date of Birth:
Street Address	E-Mail Address:	
City:	State	Zip Code:
Sex: Male or Female	◊ Married ◊ Widowed ◊ Single ◊ Minor ◊ Separated ◊ Divorced ◊ Partnered for ____ years	
Employer Name/School Name:		
Employer/School Address:		
Occupation:	Business Phone #:	
Relationship to Patient:		

Medical Insurance

Copy of Insurance Card Located Inside Chart

Emergency Contact:	Phone #:
How did you learn of our practice?	

Authorizations

Insurance Assignment and Release

I certify that I have insurance coverage with _____ (Name of Insurance Company) and assign directly to Women's Care Specialists all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above name facility may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agent for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization
I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Women's Care Specialists for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian or Personal Representative Date

Insurance Assignment and Release

I certify that I have insurance coverage with _____ (Name of Insurance Company) and assign directly to Women's Care Specialists all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above name facility may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agent for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

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I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Women's Care Specialists for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian or Personal Representative Date