Women's Care™ FLORIDA

NEW PATIENT REGISTRATION FORM

Acct#:_____

Today's Date_____
Last 4 Digits of Social Security #_____**Email**_____

Last Name_____ **First** Name_____MI_____

Nickname/Maiden Name_____

Address_____
Apt/Unit #_____

City_____ State_____ Zip_____

Home Phone (_____)_____ Work Phone (_____)_____ **Cell Phone** (_____)_____

Age_____ Date of Birth_____/_____/_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Gender: ☐ F ☐ M

Race: **(Optional)** ☐ Black ☐ White ☐ Asian ☐ Hispanic ☐ Other

Employer _____

Occupation_____

How did you hear about us? : ☐ Personal Reference_____
☐ Physician_____ ☐ Internet ☐ Yellow Pages ☐ Newspaper/ Magazine/ Television
☐ Other _____

EMERGENCY CONTACT

Name_____ Relationship_____

Home Phone (_____)_____ Work Phone (_____)_____Cell Phone (_____)_____

INSURANCE INFORMATION

Primary Insurance Company Name_____
Phone # (_____)_____
Insured Name (if other than self) _____
Relationship_____

Last 4 Digits of Social Security #_____
Date of Birth_____/_____/_____

Policy/Member #_____
Group #_____

Employer Providing Insurance_____

Secondary Insurance Company Name_____
Phone # (_____)_____

Insured Name (if other than self) _____ Relationship_____

Form Rev. 10/1/17

Last 4 Digits of Social Security # _____
Date of Birth_____/_____/_____

Policy/Member #_____
Group #_____

Employer Providing Insurance_____

PRIMARY CARE PHYSICIAN

Name_____ Phone # _____

PHARMACY

Name_____ Phone #_____

PHI DISCLOSURE

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss your care with. Your PHI will be disclosed to the individual(s) listed below unless you notify us otherwise in writing.

_____ _____

_____ _____

Please specify anything that you do NOT want to be released:

_____

I understand this authorization extends to all or any part of my medical record, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol /drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on the authorization. I understand that my PHI used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my PHI may no longer be protected by law. **Parents/Guardians: Minor patients may consent to certain services and limit access to certain protected health information such as care related to pregnancy, birth control, STIs/STDs, and HIV under state law.**

INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize Women's Care Florida to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Women's Care Florida on behalf of myself and/or my dependents, and I understand by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medigap, private insurance and any other health/medical plan to issue payment directly to Women's Care Florida, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, regardless of insurance coverage.

CONSENT TO TREAT

The purpose of medical care is to facilitate the treatment of disease, injury and disability. Medical services are provided through examination, testing and use of procedures to the aid of diagnosis or treatment of a medical condition or conditions. I request and authorize Women's Care Florida to provide me with medical services as described above. I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of medical care/services that is established.

I acknowledge I have received a copy of the Women's Care Florida "Notice of Privacy Practices". I have read and understand all of the above and agree to comply.

Date_____Signature_____

Responsible Party Signature (required if patient is under 18):

_____

To be completed by office staff, if applicable:

On this date the patient presented for treatment and was provided with a copy of the practice's Notice of Privacy Practices. Although a good faith effort was made to obtain a written acknowledgement of receipt of Notice of Privacy Practices, one was not obtained because:

____ Patient refused to sign.

____ Patient was unable to sign or initial because: _____

_____

Responsible Party – Adult present signing consent to treat

Relationship to Patient_____

Last Name_____

First Name_____ MI_____

Last 4 Digits of Social Security # _____ Date of Birth_____/_____/_____

Gender □F □M

Address_____

Apt/Unit #_____

City_____ State_____ Zip_____

Home Phone (_____)_____ Work Phone (_____)_____