WOMEN'S OB GYN, P.C.
PATIENT REGISTRATION

Answer all questions and bring this with you on the day of your appointment – **DO NOT MAIL.**

Name: ______________________ **DOB:** __________ **SS#:** ______________
Address: ______________________ **City:** __________ **State:** ______ **Zip:** __________
Primary Phone #: ______________________ **Work #:** ______________ **Cell # :** __________
Email: ______________________ **Marital Status:** ______ **Gender:** ______
Race: ______________________ **Ethnicity:** ______________ **Language:** ______
(e.g. Caucasian, Hispanic) **Patient Employer:** ______________ **Spouse Employer:** ______________
Spouse: ______________________ **Spouse Contact Number:** ______________
Emergency Contact: ______________________________________

INSURANCE INFORMATION – All of the information is required to properly bill your insurance company. If you do not provide the requested information, you will be responsible for your visit. **Please bring insurance cards and photo identification to EVERY appointment.**

Primary Insurance: ______________ **Secondary Insurance:** ______________
Subscriber Name: ______________ **Subscriber Name:** ______________
Subscriber DOB: ______________ **Subscriber DOB:** ______________
Subscriber SSN: ______________ **Subscriber SSN:** ______________
Relationship to Patient: ______________ **Relationship to Patient:** ______________
Copay: ______ ***YOUR COPAY IS DUE THE DAY OF YOUR APPOINTMENT* IT IS YOUR RESPONSIBILITY TO KNOW YOUR COPAY***

REFERRING/FAMILY PHYSICIAN – If your insurance is an HMO, then you require a referral from your family physician. If you do NOT have the required referral, YOU WILL HAVE TO PAY for your visit at the time of your visit or you WILL NOT BE SEEN.
Has your family doctor approved a referral? __________ YES __________ NO

Referring Physician: ______________ **Phone Number:** ______________
Family Physician: ______________ **Phone Number:** ______________

May we contact you with our automated appointment reminder system? ________ YES ________ NO
May we leave medical information at your primary telephone number? ________ YES ________ NO

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN:

I hereby authorize the physicians and staff of Women's OB GYN, P.C. to release to my Insurance Company any information acquired in the course of my treatment, either verbally, in writing or via fax machine. This authorization also allows the release of information to another physician in the event it becomes necessary for you to be referred to another physician. It allows the release of information to your primary care physician. This release specifically includes information with respect to communicable diseases or infections, including HIV virus (i.e., AIDS) I further hereby authorize my insurance company to pay directly to the physicians of Women's OB GYN, P.C. surgical and/or medical benefits. If any, otherwise payable to me for services rendered. I understand that amounts deemed by my insurance company to be beyond what they may consider "usual, customary, and/or reasonable" charges for said services will be paid in full by me. I also understand that I am fully responsible for any and all co-payment and deductible amounts. I understand that any service rendered to me that is not a benefit of my insurance company will be paid in full by me. I understand that my medical information, including medical history may be shared with Saginaw Valley Medical Research Group, LLC. This information will be included in a database, to be contacted for current or future studies. If I decide to not allow my information to be used in the database, at a future time, I will contact Women's OB/GYN, P.C. or Saginaw Valley Medical Research Group, LLC.

Signature: ______________________________ Date: ______________

I HAVE BEEN OFFERED OR RECEIVED A COPY OF THE WOMEN'S OB GYN, P.C. NOTICE OF PRIVACY PRACTICES. PLEASE INTIAL: __________ **DATE:** __________

Please note: If you fail to keep three consecutive appointments without notifying us in advance, it will result in termination of your care with this office. Also, please be aware that we strive to treat each of you with kindness and respect at all times and ask that you treat each of our staff member the same.
Date: ______ Init: ______ Date: ______ Init: ______ Date: ______ Init: ______ Date: ______ Init: ______ Date: ______ Init: ______

PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE

Please print all information, then sign and date form at bottom.

Patient Name ____ Chart Number _____________

Purpose of request - I authorize Women's OB Gyn, P.C. to disclose or provide my protected health information to the following individuals who are authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, they may exercise my right to inspect, copy, and correct my protected health information:

1.____ Relationship ______________

2.____ Relationship ______________

3.____ Relationship ______________

4.____ Relationship ______________

Description of information to be disclosed - I authorize Women's OB Gyn, P.C. to disclose all my protected health information to my designated personal representative.

Expirations or termination of authorization - This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to revoke or terminate - As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Re-disclosure - We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed to them, under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

____ ________________

Patient Signature Date