Women's HEALTH WISE

Patient Registration Form

Patient Name (Legal Name): _____ Date: _____

Email: _____

Address: _____ City/State/Zip: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

SSN#: _____ Birth Date: _____ Marital Status: _____

Preferred Pharmacy: _____ Location: _____

Employer: _____ Occupation: _____

Emergency Contact: _____Relationship: _____ Contact Phone: _____

Primary Care Physician: _____ Referred By (Doctor, Friend): _____

If Patient is under 18 please fill in the following blanks

Parent/Guardian Name: _____ Phone #: _____

Address (if different from patient): _____

Relationship to patient: _____

Please Read the Following Disclosure Carefully Before Signing

I hereby assign to Women's Health Wise all monies to which I am entitled for medical and/or surgical expenses relative to the service rendered by the practice, but not to exceed my indebtedness FULLY to said medical practice. It is understood that any monies received from my insurance company (named on the insurance form), over and above my indebtedness, will be refunded to me or my insurance company(s), as is determined to be appropriate, when my bill is paid in full.

I understand I am financially responsible to Women's Health Wise for charges not covered by this assignment.

A service charge of 15% will be added to all unpaid accounts over 90 days. In the event I default, I agree to pay, whether or not legal proceedings are instituted, a reasonable COLLECTION FEE of 15% which shall be added to the principal balance on my account. I also agree to pay all reasonable LEGAL COSTS as a result of my default.

I UNDERSTAND THAT ALL COPAYS AND DEDUCTIBLE AMOUNTS WILL BE DUE AT THE TIME OF SERVICE AND WILL NOT BE BILLED TO ME UNLESS PRIOR ARRANGEMENTS HAVE BEEN ESTABLISHED.

Signature of Patient/Responsible Party: _____

*****Although we are happy to send insurance claims on your behalf, full payment for services is ultimately the responsibility of the Patient/Responsible Party.***