SAN FRANCISCO WOMEN'S HEALTHCARE, INC.
PATIENT REGISTRATION FORM
450 Sutter Street, Suite 1108
San Francisco, CA 94108

1. Date: _____

2. Name: _____ _____
   Last First Middle Name
3. Address: _____
   Street City State Zip
4. _____ 5. _____ 6. _____
   Birth Date Social Security # Preferred Language
7. _____ 8. _____ 9. _____ 10. _____
   Home Phone # Cell Phone # Work Phone # E-Mail address:

11. _____ 12. _____
    Occupation Employer's Name
13. _____
    Employer's Address

14. _____ _____ _____ _____
    Spouse/Partner Name Relationship Birth Date Social Security #
15. _____ and _____
    Spouse / Partner's Employer Spouse / Partner's Occupation

16. _____ and _____
    Spouse / Partner's Employer Address Work Phone #

17. In case of emergency, notify: _____
    Name Relationship
    _____
    Phone # Address

18. Do you have medical insurance? / / yes / / no

Insurance Co.: _____ Membership ID # _____
Subscriber's Name: _____ Policy / Group #: _____
Secondary Ins. Co.: _____ Membership ID #: _____
Subscriber's Name: _____ Policy / Group #: _____

19. Do you have Medicare? / / yes / / no
20. Did you sign the Advanced Beneficiary Notice (If you have Medicare)? / / yes / / no

21. I was referred by: _____

22. My Primary Care Physician is:
    _____

Financial Policies

1. A majority of our patients have some type of health insurance coverage. The insurance contract is between you, your employer and the insurance company. Before you seek services, be sure to know what is covered and what is not. Our office will assist you to receive the maximum allowable benefits on your plan but this responsibility is yours. We recommend that you review the "Exclusions" page on your written policy and document your phone conversations with your insurance claims representative. Be sure to obtain prior authorization before having any visit or procedures that require "Prior Authorization".

2. Your doctor will make recommendations for tests and procedures as medically necessary and in the interest of preventative care. We can only order or bill for these services with your permission and understanding that all charges not covered by your insurance will be your responsibility.

3. Be sure to bring a current and verifiable insurance card to each visit with your doctor. Our policy is to collect all copayments and payments toward your deductible at the time of service.

4. If insurance is verifiable, the balance remaining after the insurance portion is paid or denied will be due within thirty (30) days. If insurance is not verifiable when you arrive for your visit, we require full payment for care at that time. Patient's without insurance coverage are expected to pay at the time of service. Please note that returned checks are subject to a $25.00 fee.

5 Your signature on this sheet verifies your understanding of the financial policies and agree to follow them. You are also confirming that the insurance and personal information is true and will notify the office of any changes. Your signature authorizes the release of any information required to process a specific claim and assigns all medical and/or surgical benefits which you are entitled which you are entitled, including Medicare, private insurance, and any other health plans to the doctors and providers under: San Francisco Women's Healthcare, Inc.

6. This assignment will remain in effect until removed by me in writing. A photocopy of this assignment is to be considered valid as an original.

7. The patient has the responsibility to go to a laboratory and/or hospital that are contracted with their health plan for services to guarantee benefit coverage. If your health plan covers the laboratory and hospital tests and/or procedures (i.e. PAPS, lab tests, cultures for STD screening, pathology), the laboratory and/or hospital will bill your health plan or patient separately for these services and the doctor's office is not responsible for the bill from outside parties. If you are not aware of the benefit coverage for laboratory tests or hospital services, refer to your insurance benefit booklet or contact your health plan company for assistance.

X _____ **Date:**_____

(Signature)

_____

(Printed Name)