

# Patient Registration

OFFICE USE ONLY

<input type="checkbox"/>	New Patient
<input type="checkbox"/>	Current Patient UPDATE
<input type="checkbox"/>	OB/GYN (circle)

Please Complete All

				Date	Acct No.	
Patient Name Last First Initial				Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home Address		City State Zip		Home Telephone		
Employer/School		Employer/School Address			Work Telephone	
Occupation	Social Security Number	Driver's License No. State	Birth Date	Age	Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse or Parent Name		Employer's Address			Work Telephone	
Name of Financially Responsible Person (if Different from Patient) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other						
Address (if Different from Patient)				Home Telephone	Work Telephone	
Primary Health Insurance Co. Name		Policy Holder		Policy Holder's Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other		
Insurance Co. Address		ID/Policy No.	Group No.	Coverage Code	Effective Date / /	
Secondary Health Insurance Co. Name		Policy Holder		Policy Holder's Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other		
Insurance Co. Address		ID/Policy No.	Group No.	Coverage Code	Effective Date / /	
Family Physician	Referred By	Address		Reference No.	Telephone	
Any Member of Family Treated by Our Group Before <input type="checkbox"/> Yes <input type="checkbox"/> No		Emergency Contact				Telephone
Your Current Problem: Work Related? <input type="checkbox"/> Yes <input type="checkbox"/> No Accident Case? <input type="checkbox"/> Yes <input type="checkbox"/> No Automobile Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Have You Missed Time From Work? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify dates)				If Due to Work-Related Injury, Fill out the Section Below.		
Date of Injury / /	Was Injury Reported to Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Supervisor			
Employer at Time of Injury		Address			Telephone	
Description of Injury:						
Workers' Compensation Insurance Carrier					Claim Number	
Workers' Compensation Insurance Carrier Address					Telephone	
Is Attorney Assisting You With This Worker's Comp Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Attorney's Name		Address			Telephone	

Email

Address \_\_\_\_\_

Patient Name \_\_\_\_\_

**MESSAGE AUTHORIZATION**

WARNER WELLNESS INSTITUTE

\_\_\_\_\_  
(Name of Provider/Clinic)

considers patient confidentiality to be of utmost importance and concern. In an effort to ensure that your privacy is protected, please read and sign the following consent form.

**AUTHORIZATION**

I authorize the provider/clinic to leave on my **home** answering machine, telephone number \_\_\_\_\_ or information left on my **work** voicemail, telephone number \_\_\_\_\_; pertaining to the following (check all that apply):

- ☐ Date and time of upcoming appointment
- ☐ Laboratory results (e.g., blood test, Pap smear, urine or other cultures)
- ☐ X-ray, CT scan, MRI or other radiological results
- ☐ Reminder to schedule recurring screening services or testing (e.g., Pap, annual)
- ☐ Email Address \_\_\_\_\_ for information related to our office including upcoming office promotions.

I understand that this authorization will remain in effect until such time that I submit, in writing, revocation of my authorization. I understand that by giving my consent, information about my personal health care could be made available to members of my family and/or others in my home who have access to my telephone messaging system.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NO AUTHORIZATION**

☐ I **do not** authorize any messages related to my health care to be left on my **home** answering machine.

☐ I **do not** authorize any messages related to my health care to be left on my **work** voicemail/answering machine.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**AUTHORIZATION REVOKED**

Message authorization revoked on \_\_\_\_\_

Initials of individual receiving written revocation: \_\_\_\_\_

WARNER WELLNESS INSTITUTE  
Prescription Refill Request

Patient Instructions:

In order to obtain a refill for your prescriptions, please complete this form and fax it to (202) 723-1992. This form cannot be used to request a new or change of a medication.

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ work: \_\_\_\_\_ cell: \_\_\_\_\_

Address: Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Medication and Dosage: \_\_\_\_\_

Frequency Used: \_\_\_\_\_

Please select one of the following:

\_\_\_\_\_ Mail prescription to my home address to use at a local pharmacy.

\_\_\_\_\_ Mail prescription to my home address to use with a mail order pharmacy.

\_\_\_\_\_ Call in the prescription to my pharmacy:

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone#: \_\_\_\_\_

Office Use Only:

\_\_\_\_\_ Prescription mailed on: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Prescription called into pharmacy on \_\_\_\_/\_\_\_\_/\_\_\_\_ Spoke with: \_\_\_\_\_

\_\_\_\_\_ Prescription not refilled because: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_



## WARNER WELLNESS INSTITUTE

### Statement of Patient Financial Responsibility

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

WARNER WELLNESS INSTITUTE appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full for our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to WARNER WELLNESS INSTITUTE, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Green Pregnancy and Center for Women's Health, the full entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

(If guarantor is not the patient)

#### Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

#### Consent for Treatment and Authorization to Release Information

I hereby authorize WARNER WELLNESS INSTITUTE, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment.

I further authorize WARNER WELLNESS INSTITUTE, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours (one business day) prior to cancelling your appointment or rescheduling your appointment or you will be charged a \$50.00 fee.

I have read and understand the above information, and I agree to the terms described.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Form Completion and Replacement for Lost Items

Should you require forms for employment, school, disability, or any other purpose; you must assume the cost of preparing these forms. There must be a signed authorization form from the patient accompanying these forms. Forms request must be provided at least one week before the due date. The charge for form completion is \$25.00 per form.

The practice provides prescriptions that are medically necessary and appropriate in your treatment, referrals for radiology, and requisitions for laboratory testing. If any of these items are lost and a replacement is necessary; there is a \$25.00 fee that must be paid before the replacement is provided.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

.Self-Pay

I do not have health insurance and will be responsible for services rendered here at WARNER WELLNESS INSTITUTE. I agree to pay WARNER WELLNESS INSTITUTE, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_