TAHOE WOMEN'S CARE REGISTRATION FORM

Please give the Receptionist a picture ID and your insurance card(s) so that we may retain a copy.

Thank you for taking the time to update your records. *We ask each year for you to complete new forms in order to be compliant with new regulations by government and/or the insurance companies. We are also asking for your email in order to allow you to use our new Patient Portal that interfaces with our electronic medical record. However, if there are any questions you do not want to answer, please put an N/A in that Slot so that we know you did not miss it. When there are multiple choices, please circle.

PATIENT INFORMATION:

Date _____

Patient's Full Legal Name _____ Social Security # _____

Previous name (if different) _____ Date of Birth _____

Mailing Address _____ City _____ Zip Code _____

Physical Address _____ City _____ Zip Code _____

Home phone _____ Cell phone _____ Work _____

Primary Care Physician _____Your email address _____

Marital Status – Married Single Divorced Partner Widowed

*Language – English Spanish Other _____

*Do you need an interpreter in order to understand medical or billing information? Yes No

*Race – White Hispanic Asian African American Other _____ Unreported Decline

*Ethnicity – Hispanic Non-Hispanic Decline to answer

Other Information (Equally Important)

Nearest relative not living with you –

Name _____

Relationship to you _____

Address _____

City _____

State _____Zip _____

Phone number _____

In the event of an Emergency, please notify -

Name _____

Relationship to you _____

Address _____

City _____

State _____ Zip _____

Phone number _____

How may we contact you?

Home phone _____ OK to leave message _____

Cell phone _____ OK to leave message _____

Work phone _____ OK to leave message _____

Email _____ OK to leave message _____

How did you find our practice?

Established Patient since (approx.) _____

Website _____ Newspaper _____ Magazine _____ Friend _____

Referral from other MD _____ If so, which physician? _____ Other _____

Employment Information

Patient's Occupation _____ Patient's Employer _____

Address _____ Phone Number _____

Subscriber's Occupation _____ Subscriber's Employer _____

Address _____ Phone Number _____

******Patient and/or Subscriber's Insurance Information******

Primary Insurance Carrier _____ ID _____

Subscriber's Full Name _____ Relationship to Patient _____

Subscriber's Date of Birth _____ Subscriber's Social Security Number _____

Mailing Address _____ City _____ Zip _____

Physical Address _____ City _____ Zip _____

Secondary Insurance Carrier _____ ID _____

Subscriber's Full Name _____ Relationship to Patient _____

Subscriber's Date of Birth _____ Subscriber's Social Security Number _____

Mailing Address _____ City _____ Zip _____

Physical Address _____ City _____ Zip _____

Your Preferred Lab

If we send specimens from our office, i.e. Pap smears, blood work or Pathology, etc. your insurance company May have a preference which lab is used and your benefits could be affected. Please indicate which lab your insurance company prefers. If you do not know, we will be happy to call your insurance company while you are here in the office. If you do not know, we will NOT automatically check on this. If you have any questions about PAP smears or any other lab work ordered by this practice, please discuss with your provider.

Western Pathology _____ Lab Corp _____ Quest Diagnostics _____ Barton Lab _____

Preferred Pharmacy

_____ at _____

Patient Record of Disclosures

Who may we release medical information to: No One _____

Name _____ Relationship _____

Name _____ Relationship _____

XX Signed _____ Date _____

Mountain Meadows Medical Group, dba Tahoe Women's Care Notice of Privacy Rights

The federal regulation under the Health Insurance Portability and Accountability Act (HIPAA) requires that all patients be made aware of how their Private Health Information (Medical Records) is accessed, used and disclosed. In accordance with those regulations Tahoe Women's Care is required to make available to all patients a "Notice of Privacy Practices". I have been offered and have available to me a copy of Tahoe Women's Care Notice of Privacy Practices.

XX Signed _____ Date _____

Insurance Payment Release of Information

I hereby authorize my insurance carrier(s) to pay you directly for bills incurred for services that were provided to me by physicians or providers of Mountain Meadows Medical Group dba Tahoe Women's Care. I authorize you to release to my insurance carrier(s) my medical records pertaining to my medical care and treatment. I fully understand that no other information than this document is necessary to release this information. This release of information is still in compliance with HIPAA regulations.

XX Signed _____ Date _____

Medicare Subscribers

"I request payment of all authorized Medicare benefits be made on my behalf to this office for any services provided by a physician or provider at Mountain Meadows Medical Group dba Tahoe Women's Care. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services."

Patient (or authorized Signer) **Print Name** _____

XX Patient (or authorized Signer) **Sign Name** _____

Medicare ID Number _____ Date _____

Tahoe Women's Care Financial Policy

Thank you for choosing us as your health care provider. We are committed to providing you with optimal patient care and treatment necessary to maintain and restore your health.

All charges are YOUR responsibility regardless of insurance coverage. Not all services are covered by all insurance contracts and it would be impossible for us to know what coverage YOUR provider includes, although we try very hard to obtain that information. Please take the time to familiarize yourself with the information provided by your insurance carrier.

While we will bill your insurance as a courtesy, if there is a delay in payment by your carrier, the bill remains your responsibility.

Please note if a specimen is sent from this office to a laboratory, you will receive a separate bill from that lab the bill will be your responsibility. Please be certain we have the correct information concerning the lab you prefer.

Payment of co-pays and deductibles are due at the time of service. We accept cash, checks, Visa and Mastercard. If you are having a procedure or surgery, you may be asked to pay an estimate of your portion not covered by your insurance.

I have reviewed the financial policies of Tahoe Women's Care and I understand that I am responsible for all the charges for medical services not paid by my insurance plan. I am responsible for knowing what coverage is provided.

Patient Print Name _____

XX Patient Sign Name _____

Dear Patient,

We would like to inform you, we have entered into an age of extreme complexity with regard to the number of insurance companies that are available. Each insurance company offers various policies, as well as the diversity of provisions and the restrictions that are present with many of these policies. For instance, does your insurance cover an annual well-woman examination? Are you restricted as to where you can go for diagnostic studies? Are there certain laboratories that you can be referred to for Pap smears, cultures and blood work? We will help you to the best of our ability but it is ultimately YOUR responsibility to know what provisions, restrictions and requirements are included/excluded in your specific health insurance policy.

We would like to inform all our patients that if you are here for an annual examination it is OUR policy to obtain a Pap smear based on ACOG guidelines. Depending on your health history and the reason for your visit, Chlamydia and/or genital cultures or blood work may be ordered as well. These tests are sent to an outside laboratory. The fee for Pap smears, cultures and/or blood work obtained in our office is a separate fee and is not included in the fee for your office visit. It is ultimately YOUR responsibility to know which laboratory is a provider for your insurance company. This office sends lab work to Lab Corp. If your insurance company is not affiliated with Lab Corp you must tell the nurse so we can send your work to the correct lab.

By your signature, you are acknowledging you have read this notice and are aware of these issues. Thank you.

_____

Patient's Signature

_____

Date