Advanced Women's HealthCare, SC

Registration Form

Account #

Provider

Patient Full Name Last First Middle Maiden(0ther)

Address Street Apt/Suite#

City State Zip Code

Phone # (Please circle preferred contact number) Home Cell Work

Can Messages be left on voice mail? Home: Yes / No Work: Yes / No Cell: Yes / No

I authorize AWH to discuss my Protected Health information with the following person/s (please include date of birth):

Martial Status: Single Married Divorced Widowed

Sex (circle one) Female Male

Date of Birth:

Social Security Number of Patient:

Ethnicity & Race:

Patient Employer:

Spouse employer:

Emergency contact person for patient: (Is this person listed in release to following person section?) Name Phone Relationship

Information below this line is for Responsible Party ---The person responsible for payment of bills

Name of Responsible Party Last First Middle Date of Birth

Address Street Apt/Suite#

City State Zip Code

Phone # Home Cell Work

Primary Insurance Carrier Name Effective Date

Subscriber ID# Group # Employer

Subscriber full Name Last First Middle Social Security Number Date of Birth

Relationship to Patient: (circle one) Self Spouse Child Other (explain)

Copy of this insurance card in file Yes No

Phone # Home Cell Work

Secondary Insurance Carrier Name Effective Date

Subscriber ID# Group # Employer

Subscriber full Name Last First Middle Social Security Number Date of Birth

Relationship to Patient: (circle one) Self Spouse Child Other (explain)

Copy of this insurance card in file Yes No

Is this visit related to an accident: Yes No If yes, date of accident

Must provide Insurance Claim number: If no claim number visit/s will be billed as self pay

Financial Agreement

We accept most insurance plans and submit claims to those plans on your behalf. The accuracy of the information we request on the previous page is important so all your insurance plans requirements are met prior to providing services and submitting your insurance claim.

It is your responsibility to pay for all services provided that are not covered by your insurance. That includes any amount denied, not covered, co pay by your insurance plan. Not all services are covered benefits with all insurance co. It is your responsibility to pay for all services not covered by your insurance. That includes non-covered services, copay, & deductible. Payment for the above are expected at the time of service. We accept cash, checks and most credit cards.

Any check returned for non Sufficient funds will be charged $25.00.

Payment arrangements for OB patients are due as per written agreement which will be discussed at your first prenatal visit

Payment of unpaid balances are due prior to any new services being provided. Appointments will not be scheduled until balance is paid in full.

Should your account becomes deliquent it will be assigned to a collection agency, you will be responsible for the costs incurred in collection of this balance, which includes collection agency fees of 30 %, court costs and attorney fees and we will be unable to schedule you for any further appointments.

I have been informed that **effective June 25, 2013** Advanced Womens Healthcare, S.C. no longer accepts Medicaid as a secondary payer and I understand that it is my responsibility to pay any co-pays and deductible required by my commerical insurance. **Initial** _____

I authorize Advanced Women's Healthcare, S.C. to release to my health insurance carrier and its agents any information to determine the benefits payable under their coverage. I authorize my insurance company and its carriers to disclose any information requested regarding claims for medical benefits,

A copy of this authorization may be used in place of the original.

I am aware if I decline to consent to this release of information I am responsible for all charges I incur while being treated.

I also state that the information provided regarding insurance coverage is accurate and true. **Initial**_____

After reading Advanced Women's Healthcare, S.C. Financial agreement I understand and agree that I am responsible for payment of any non-covered services not paid by your insurance policy.

Your signature below indicates that you understand and agree to the above financial agreement.

Signature of patient (or guarantor if patient is a minor) _____

Name of patient or guarantor (Please print): _____

If signed by guarantor, please print name of patient: _____

Patient DOB Date signed:

Consent to Treat

I hereby authorize employees and agents; physicians, mid level practitioners of Advanced Women's Healthcare, SC office to render medical care to the patient indicated on this form and to fulfill the orders of the physicians: including consultants, associates and assistants of the physician choice.

Signature of Patient, Parent or Legal Guardian: _____ Date: _____

If patient is a minor:

My signature above authorizes evaluation and treatment for my child and also authorizes consent to medical and surgical procedures for the child named herein _____ (Name of child).

Authorization for AWH to send test results and patient portal information via e-mail

□ I, _____authorize AWH to send my test results
(Patient Name)

and patient portal information via e-mail address:

_____
(e-mail address)

□ I,_____**DO NOT** authorize AWH to e-mail test results
(Patient Name)

and patient portal information via e-mail. DATE:_____

Effective 09/01/2013

The attached notice describes how medical information about you may be used and disclosed. It also describes how you can get access to this information. Please review it carefully.

I reviewed or received a copy of Advanced Women's Healthcare, S.C. Notice of Privacy Practices

Please sign which applies below:

Signature of Patient	Date
Patient's Printed Name	Patient's Date of Birth or MRN
Signature of Parent/Legal Guardian/Legal Representative	Date of Signature
Printed Name of Parent/Legal Guardian/Legal Representative	Relationship to Patient

Healthcare regulations, required that we ask the following questions:

1. What category best describes your race? If you need additional definition please ask the front desk

☐ African American ☐ American Indian or Alaska Native ☐ Asian

☐ Caucasian ☐ Native Hawaiian or other Pacific Islander ☐ Do not identify with any of the above captions

☐ Decline. I do not want to answer

2. Do you consider yourself Hispanic or Latino?

☐ No. Not Hispanic/Latino ☐ Decline. I do not want to answer

☐ Yes. Hispanic/Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, Latin American or Spanish culture or origin

3. What is your preferred language?

☐ Arabic	☐ Assyrian	☐ Bosnian	☐ Bulgarian	☐ Cantonese
☐ Croatian	☐ English	☐ French	☐ German	☐ Greek
☐ Gujarati	☐ Hindi	☐ Italian	☐ Japanese	☐ Korean
☐ Malayalam	☐ Mandarian	☐ Polish	☐ Russian	☐ Serbian
☐ Spanish	☐ Sign Language	☐ Tagalog	☐ Vietnamese	☐ Other

ELECTRONIC PRESCRIPTIONS: Our electronic medical record program assesses your prescription/medication history in order for us to safely prescribe your medication. By signing this you authorize us to do so

IMMUNIZATION: Our electronic medical record program allows for your immunization data to be sent directly to the I-Care State of Illinois Registry. I-Care allows your providers to obtain you immunization history to ensure you safety. By signing this you authorize us to submit this data.

SIGNATURE: _____ Date: _____