PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose ☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc ☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian ☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____ Would you like to be enabled with our patient portal? Yes No

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)_____(First)_____(MI) _____

Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number:_-_____-_____Phone number: _____

Address:_____

City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____

Phone number:_____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:_____ ☐ Guardian

Address_____

City, State:_____ZIP: _____

Home phone:_____Work phone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

Primary care physician information:

Name: _____ Phone number: _____

Address: _____

Pharmacy information:

Name: _____ Phone number: _____

Address: _____

How did you hear about us? Circle any that apply:

Website Family/Friend Internet Search

Former or current patient (please provide name so we can thank them!) _____

Physician (please specify): _____

Other Healthcare facility (please specify): _____

Insurance network (please specify): _____

Other (specify): _____

Patient name: _____
Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, CONSULTANTS IN OBGYN may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge CONSULTANTS IN OBGYN may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to CONSULTANTS IN OBGYN any insurance or other third-party benefits available for health care services provided to me. I understand CONSULTANTS IN OBGYN has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to CONSULTANTS IN OBGYN agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to CONSULTANTS IN OBGYN by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for CONSULTANTS IN OBGYN, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that CONSULTANTS IN OBGYN or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or CONSULTANTS IN OBGYN or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ Date: _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _____

Health ONE Consultants in Obstetrics and Gynecology
Physician Care℠

Thank you for choosing Consultants in Ob/Gyn for your healthcare. In order to achieve our goal of providing and maintain a good physician-patient relationship we believe it is important to have a solid financial policy in place. We also believe that these policies will allow us to provide our patients with high quality, cost-effective care. We ask that you carefully read and sign the following Consultants Financial Policy prior to your treatment.

1. Upon arrival, please sign in at the front desk and present your current health insurance card as well as your driver's license or another acceptable form of ID. You will be asked to present both of these items at each visit for proper identification.
2. If you do not have health insurance coverage, or we do not participate with your insurance plan you will be given a 35% discount. Acceptable forms of payment are cash, check or credit card.
3. You are responsible to have complete insurance information available for Consultants so that we may accurately file your claims. Complete insurance information includes current benefit cards (primary and secondary), and proper identification.
4. You are responsible for checking with your insurance plan regarding any co-payments, deductible or co-insurance that you may owe at the time of service.
5. Co-payments are a contractual obligation with your insurance company. You are required to pay you co-payment, and we are required to collect your co-payment at the time of each visit. Co-payments are collected prior to service.
6. If the insurance information that you provide at the time of your visist is incorrect, you will be responsible for payment of your visit and to submit the charges to the correct plan.
7. For indemnity-type health insurance plans, insurance payments received by Consultants will be applied to your account and you agree to pay the balance.
8. If you have HMO or PPO health insurance plan and our physicians participate in your health insurance plan, we will accept payment from the carrier for services covered by your benefit plan.
9. If you undergo a surgical procedure, in addition to a bill from your surgeon you may also receive bills from the hospital where the procedure is performed, anesthesia, pathology/lab, radiology and various consultants.
10. Not all services provided by our office are covered by every health insurance plan. Any service determined NOT to be covered by your plan will be your responsibility.
11. Consultants is committed to providing the best treatment for our patients; however you are responsible for any unpaid balance regardless of your insurance company's arbitrary determination of usual and customary rates.