CONFIDENTIAL PATIENT REGISTRATION

Copies of your insurance cards must be presented and will be copied and verified.
A copy of your driver's license is required.

PATIENT INFORMATION

Name: ______________________ Social Security #: ______________________ Race: ________

Address 1: ______________________ Home Phone #: ______________________

Address 2: ______________________ Cell Phone: ______________________ Date of Birth: ________

City, State, Zip: ______________________ Age: ________

Referring MD: ______________________ Primary Care MD: ______________________

Marital Status: [ ] Married [ ] Single [ ] Widowed E-Mail: ______________________

PATIENT EMPLOYMENT

Employer Name: ______________________ Phone: ______________________

SPOUSE'S INFORMATION

Name: ______________________ Social Security #: ______________________ Date of Birth: ________

Employer Name: ______________________

EMERGENCY CONTACT(S)

Name: ______________________ Phone: ______________________

Name: ______________________ Phone: ______________________

How did you hear about us?

____ Family ____ Friend ____ Church ____ Word of Mouth ____ Yellow Pages Ad ____ MD Referral ____ Other

Would you like information regarding a living will or Power of Attorney? ____ Yes ____ No

Patient Authorization

Regardless of your insurance coverage, you as the patient, are always responsible for the payment of your charges. A surgical and/or obstetrical deposit may be required if necessary. Our office requires that all co-pays be paid prior to being seen by the provider unless you have Medicare or an insurance our office is contracted with. Office charges are to be paid by cash, check or credit card at the time of service. Counselors are available to discuss large dollar charges and payment schedules.

Authorization & Assignment:

I authorize WCG to release any information acquired by my physician/or staff to my insurance carrier(s). I authorize payments directly to my physician. I recognized and accept responsibility for any balance or fees not covered by insurance. I agree to pay the balance in a prompt manner. In any event this account is referred to an outside agency, credit reporting bureau or attorney for collection, I agree to pay all attorney fees, collection costs, court costs and/or any other expenses incurred in its collection, according to the 1989 statues of the State of Tennessee.

Patient or Responsible Person's Signature: ______________________ Date: __________

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Acknowledgement of Notice of Privacy Practices/ Patient Authorization

I have been given the opportunity to review the Notice of Privacy Practices and understand that the Notice describes how my protected medical information may be used and disclosed and how I may get access to this information. I have also been given the opportunity to take a copy of the Notice of Privacy Practices for further review.

If for some reason the facility needs to relay my protected health information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

By signing below, I agree to the aforementioned statements:

______________________ ______________________
Patient Name (Printed) Date

______________________ ______________________
Patient Signature (patient must sign regardless of age) Account Number/Chart Number

PATIENT DISCLOSURE AND AGREEMENT

Your insurance contract will not cover more than one of the following visits per day. These visits cannot be combined. If you have more than one of the following we will be happy to schedule an appointment specifically for that reason for another day. This also helps our office respect your time and other patient's time by staying on schedule.

Indicate only one of the following:
_____Annual Gynecologic Examination (breast and pelvic exams, Pap smear, prescription refills)
_____Problem or Follow up Examination (bleeding problems, infections, pain, hormonal problems, menopause, surgery scheduling, contraception counseling, follow up Pap smear, post partum, post operative etc.)
_____Consultation for a Second Opinion or Consultation from a referring physician

If you are scheduled for the following, please indicate which one(s). Insurance contracts allow these tests to be performed on the same day as one of the above visits or on a separate day.
_____Lab Tests/Injection _____Bone Density (DEXA) _____Pelvic Ultrasound _____Urodynamics

Indicate what your insurance contract covers:
_____Annual gynecologic examinations _____Problem visits by a gynecological specialist
_____Consultations by gynecological specialist
_____Diagnostic tests _____No coverage, but I want to be seen for the above indication anyway _____I know I may be responsible financially for these expenses.

Patient or Responsible Person's Signature:______________________ Date:__________