Pacific Women's Obstetrics & Gynecology Medical Group

Confidential Registration Information (Please print clearly and fill out form in its entirety. Thank you)

Today's Date _____Physician_____ Name you wished to be called _____

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PATIENT INFORMATION (Please use full name as listed on insurance card)

Last Name_____ First Name _____ MI_____

Date of Birth_____ Age_____ Social Security Number _____ Occupation_____
Marital Status: Single ____Married _____Domestic Partner _____Divorced _____Widowed _____

Race _____Ethnicity_____ Preferred Language_____

Home Address _____City, State _____ Zip _____

Phone Numbers: Cell _____ Home _____Work_____Email_____

Employer Name _____

Address, City, State, Zip _____

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SPOUSE-PARTNER-PARENT (if minor) INFORMATION – Please complete

First Name_____ Last Name_____

Relationship to Patient_____ Date of Birth_____

Home Address _____City, State _____ Zip _____

Phone Numbers: Cell _____ Home _____Work_____Email_____

Employer Name _____Occupation_____

Address, City, State, Zip _____

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INSURANCE INFORMATION (ID card photocopies required)

My insurance is with _____ Plan type: HMO_____PPO _____Other _____
(Name of insurance company)

Insured through: Self _____Spouse _____ Partner _____Other (parent, etc.) _____ Do you have an HSA? Yes ___No ___

If you have insurance through spouse/partner/other; please complete information below

Name_____ Relationship to Patient_____

Date of Birth _____ Social Security Number _____

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Referred by _____Primary Care Doctor _____

Do you anticipate any upcoming changes to the information above? Yes _____No_____ If yes, what _____

PLEASE READ AND SIGN BACK OF FORM

Pacific Women's Obstetrics & Gynecology Medical Group
Policies and Practices

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The staff and providers at Pacific Women's Obstetrics & Gynecology Medical Group appreciate that you have chosen us for your Obstetrics and Gynecology care. In order to facilitate our relationship, we want to share some of our office policies and practices with you.

Insurance: Please present your insurance information at each visit, and notify us immediately of any changes so we may properly direct claims. It is always helpful to us if you familiarize yourself with the details of your individual coverage. Some policies are quite comprehensive, while others may not cover 'well woman' examinations; IUDs, medications; or fertility services. Some benefit packages cover only 'sick' care, while others cover only 'preventive' services. We will work with you to optimize your benefits. Once we submit a claim to your insurer, we are unable to alter your diagnosis or visit code. Also be aware that, depending upon your employer & carrier, 'sick' diagnoses (such as cramps or ovarian cysts) may lead to increased insurance premiums or denial of coverage.

Prescriptions: We generally write prescriptions to cover one years' time. If needed, call your pharmacy directly for refills. We are unable to fill prescriptions at night, on the weekend, or via email. We happily accept faxes from your pharmacy with a turnaround time of one business day.

Fees & co-payments: Co-payments are due at the time of service. Our office will automatically bill you for all deductibles and fees not covered by your health plan. We accept cash, checks, Visa, MasterCard, and debit cards. A $25.00 fee is applied to all returned checks.

Copying & forms: We request payment in advance for medical record copying and completion of FMLA and disability forms. The record copying fee depends upon the volume of pages involved. For HIPPA compliance, all requests must be in written form, signed by you. We process these requests as fast as we can. The disability form fee is $15 per form (includes postage). Please be sure you have completed your portion of any disability or FMLA forms. We accept checks, Visa, MasterCard, and debit cards for these services.

Missed appointments: We must assess a NO SHOW fee for missed appointments not cancelled at least one business day prior to the scheduled visit. Current medical economics has forced this requirement, since our overhead costs (rent, payroll, malpractice insurance, etc) run several hundred dollars per hour. Our only source of revenue is office visit payments, so we must fully book our schedules in order to cover our ever escalating expenses. If we are able to fill the vacant slot, we will not charge the fee.

Assignment of Insurance/Plan Benefits
I hereby authorize direct payment of insurance benefits to Pacific Women's Obstetrics & Gynecology Medical Group for services rendered by the physician in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Medicare Insurance
I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefit be made to the physician on my behalf.

Lab/X-Ray/Diagnostic Services
I understand that I may receive a separate bill if I receive lab, x-ray or other diagnostic services. I understand that PWOG has no influence or affiliation with these entities. As such, I understand I am personally responsible for knowing which ancillary procedures are covered by my medical plan. I understand that I am financially responsible for any balance not covered by my insurance for these services.

We are always eager to hear your feedback on how we can do a better job for you. Please feel free to speak with your physician directly if you have suggestions or concerns.

I have read and understand the policies and practices of Pacific Women's Obstetrics & Gynecology Medical Group

Signature of Patient_____Date_____

Signature of Guarantor_____Date_____
(if different from patient)

A copy of this form is available at our website www.pacwomens.com