PATIENT REGISTRATION

Last name		**First name**		**MI**
Address		**Birthdate**	___/___/_____	
City		**E-Mail Address**		
State/Zip		**Social Security #**	____-____-_____	
Home Phone		**Employer**		
Work Phone		**Occupation**		
Cell Phone		**Sex**	□ Male	□ Female
Preferred Pharmacy				
Preferred Method of Contact		**Preferred Language**		
May We Leave a Message?		**Emergency Contact**		
Race		**Ethnicity**		
Marital Status	□ Single □ Married □ Divorced □ Widowed			

INSURANCE INFORMATION	**Primary Insurance**	**Secondary Insurance**
Insurance Company Name		
Subscriber Name		
Birthdate Soc Sec #	___/___/_____ ____-____-_____	___/___/_____ ____-____-_____
ID#		
Group#		
Relationship to Patient		
Employer		
Occupation		

HIPAA

Because of strict government regulations regarding patient privacy (HIPAA) we cannot give any medical information to anyone without your authorization. Please list the people you have authorized to receive information regarding your medical condition.

_____

□ I do not authorize anyone to receive my medical information.

May we send practice newsletters, appointment reminders, and announcements to your e-mail address? □ Yes □ No

REFERRAL INFORMATION	Primary Care Physician	
	If a physician referred patient, please indicate full name	
	How did you hear about us? (Radio, Internet, Facebook, TV,etc.)	

PAYMENT AUTHORIZATION **INITIAL**

I hereby authorize payment directly to Premier Women's Health of Geauga for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance and for all services rendered on behalf of myself or my dependents.	
I authorize Premier Women's Health of Geauga to release information required for my care, and to secure the payments of benefits. I authorize the use of my signature on all insurance submissions.	
Unless I have specified otherwise, I authorize any specimens from myself or my dependents be sent to any laboratory deemed appropriate by Premier Women's Health of Geauga with the knowledge that the laboratory may or may not be covered in my insurance contract, and I will be responsible if sent to a non-network laboratory.	
I authorize and consent to consultation, examination, testing, and treatment by Premier Woman's Health of Geauga.	
Co-Pay and Self Pay Services are due at the time of service.	
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.	

Print Name of Responsible Party			
Signature of Responsible Party		Date	
Address (if different from patient's)			
Relationship to Patient			

_____

I wish to participate (signature)

_____

I would like to opt-out (signature)

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying our office administrator. This is a voluntary agreement. You may opt-out at any time by signing the opt-out below.