



REGISTRATION
(PLEASE PRINT)

Date Home Phone Area Code Cell Phone Area Code

PATIENT INFORMATION

Name Last Name First Name Middle Initial SS/HIC/Patient ID #
Address Age Birthdate
City State Zip E-mail
Gender F M Language Married Single Widowed Minor
Race Ethnicity Partnered years Separated Divorced
Patient Employer/School Occupation
Employer/School Address Employer/School Phone Area Code
Whom may we thank for referring you? Emergency Phone Area Code
In case of an emergency, who should be notified?

PRIMARY INSURANCE

Person Responsible for Account Last Name First Name Middle Initial
Relation to Patient Birthdate Soc. Sec. #
Address (If different from patient's) Phone Area Code
City State Zip
Person Responsible Employed by Occupation
Business Address Business Phone Area Code
Insurance Company
Contact # Group # Subscriber #
Names of other dependents covered under this plan

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No
Subscriber Name Birthdate Relation to Patient
Address (If different from patient's) Phone Area Code
City State Zip
Subscriber Employed by Business Phone Area Code
Insurance Company Soc. Sec. #
Contact # Group # Subscriber #
Names of other dependents covered under this plan

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with Name of Insurance Company(ies) and assign directly to Carolina Women's Physicians P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient/Parent/Guardian/Legal Representative Date
Please print name of Patient/Parent/Guardian/Legal Representative Relationship to Patient



Authorization For Release of Protected Health Information

****Records Over 25 Pages Please Mail to Our Office****

I authorize:

Name _____ Phone (____) _____

Fax Number of Facility Requesting From _____ Address _____

to disclose a copy of health information to Carolina Women's Physicians, PA on the following:

Patient Name _____ Phone (____) _____

Soc. Sec. # _____ Birthdate _____ Address _____

Race _____ Ethnicity _____

Language _____ Gender F M _____

The information to be disclosed shall be:

- All Records
- Labs
- Mammogram
- Pap Smear
- Pathology
- Physical Exams/Office Visits
- Prenatal
- Surgery
- Other (specify) _____

I understand the information will include records relating to:

- Alcohol and/or Drug Dependency
- HIV Antibody Test and Diagnosis/Treatment
- Mental Health Treatment

This Disclosure is being made for the following purpose:

- Continuing Care
- Insurance
- Moving
- Transfer Care

I understand that the information released cannot be re-disclosed. I also understand that the facility, its employees, officers, and physicians are hereby released from any legal responsibility of liability for disclosure of the above information to the extent indicated and authorized herein. This release will expire 30 days from the date of signature.

Signature of Patient/Guardian/Legal Representative

Date

Witness

Date



Payment Policies

The undersigned hereby agrees to reimburse Carolina Women's Physicians, PA directly for any and all services and supplies provided to the patient.

If the patient's insurance company has not paid within 90 days of billing, the patient is responsible for the balance in full. Balances owed after insurance payment are due in full within 30 days, unless other arrangements have been made through our Insurance/Billing Department.

Please Note: Insurance is filed as a courtesy for our patients' benefit. The patient/guarantor is still responsible for all charges and payments. Any benefits quoted are estimates and should not be taken as a guarantee of insurance payment. Patients are responsible for their co-insurance at the time of their visit.

Patients without insurance are expected to pay in full at the time of service. Payment is required unless arrangements have been made with the Insurance/Billing Department. The patient/guarantor understands that all amounts quoted are estimates and additional charges may incur during treatment or testing.

Unless otherwise instructed, we send all pap smears and biopsies to Greenville Pathology, PA to be read by a pathologist. We send other labs to Spectrum. **The patient will receive a separate bill from these facilities.**

All insured patients must present their current eligibility cards and pay all co-pays and co-insurance fees at the time of their visit.

Office Fees:

- Office Visit/Nurse Visit: Co-pay fee determined by patient's insurance
- Duplicate/Lost Prescription: \$25
- Forms/FMLA/Medical Records: \$15
- Non-emergent after-hours calls: \$25
- No Show/Same day cancellation: \$50

*We understand that an emergency may necessitate a late (or same day) cancellation.

In the event this occurs, the patient may not be charged a fee.

The undersigned has read and received a copy of the form and certifies that they are the patient, the patient's legal representative, or are duly authorized by the patient as the patient's general agent to execute this consent to pay for services and accepts its terms.

Signature of Patient/Guardian/Legal Representative

Date