Women's Health
Connecticut – Central Massachusetts

Patient Registration

Last Name _____ First Name_____ M_____DOB_____

Address _____ Primary Care Physician _____

Primary Insurance _____ Subscriber_____ DOB_____ Relationship _____

Secondary Insurance _____ Subscriber_____ DOB_____ Relationship _____

Primary Insurance Policy Number _____ Secondary Insurance Policy Number _____

Emergency Contact Name _____ Number_____ Relationship_____

Consent to Text: Yes ☐ No ☐ Consent to Call: Yes ☐ No ☐

I hereby authorize Physician's for Women's Health, LLC., their respective agents and business associates to contact me at any current or future telephone numbers, including wireless telephone numbers or devices which could result in charges to me. I understand that this contact may include the use of pre-recorded or artificial voice messages, text messages and may also include the use of an automatic telephone dialing system.

** Would you like a printed copy of our Notice of Privacy? Yes☐ No☐ _____ Patient's Parent of Minor's Initials

Authorization for Treatment, Payment & Healthcare Operations
I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate for services provided. As part of this authorization, Physicians for Women's Health LLC may share my medical record as part of a referral for treatment, which may include HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law unless otherwise indicated. I understand that I am financially responsible to Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as costs including attorney fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I understand an acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

Signature of Patient/Parent of Minor_____ **Date**_____

Medicare Authorization for Treatment, Payment & Healthcare Operations, Medicare Recipients Sign both Authorizations.
I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Physicians for Women's Health LLC for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

Signature of Patient/Parent of Minor_____ **Date**_____

Appointment No Show Policy
Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Missing an appointment without canceling it in advance is considered a "no show". A telephone call to the office to explain why you cannot keep the appointment might prevent a "no show" from being recorded against you.
Multiple Missed Appointments could result in termination from our practice which will prevent you from scheduling another appointment. Any upcoming routine appointments will be cancelled.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have read and understand the policy, and that all the above information is current.

Patient Name (Print) _____ **DOB**_____

Signature of Patient/Parent of Minor_____ **Date**_____