CAPITAL WOMEN'S CARE, LLC.

PATIENT REGISTRATION FORM

Please update the information below, sign the form, and return the form to the front desk. Thank you.

Patient Information

Today's Date:	Account	Referring Physician:	Appt Info:	
Name:	Marital Status:	Gender:	Date of Birth:	Social Security #:
Address:	APT #:	City,State, Zip:		
HOME MSG YES	CELLULAR MSG YES	Ext:	EMAIL	

GUARANTOR/FINANCIALLY RESPONSIBLE PARTY

Guarantor Name:	Date of Birth:	Social Security #:	Phone 1:
Address:	City, State, Zip:		Phone 2:
Employer:	Employer Address:		Occupation:

PRIMARY INSURANCE INFORMATION

Have you applied or intend to apply for Medical Assistance? ◯Yes ◯No ◯Not sure

Insurance Company:	ID #:	Group #:
Address:	City, State, Zip:	Phone:
Policy Holder's Name:	Policy Holder's Date of Birth:	Policy Holder'sSocial Security #:
Policy Holder's Employer:	Patient's Relation to Policy Holder:	Insurance Effective Date:

SECONDARY INSURANCE INFORMATION

Please note, insurance companies require you to notify them if you have other insurance. If they do not have this information in their system, they will not pay the claim for this visit.

Insurance Company:	ID #:	Group #:
Address:	City, State, Zip:	Phone:
Policy Holder's Name:	Policy Holder's Date of Birth:	Policy Holder's Social Security #:
Policy Holder's Employer:	Patient's Relation to Policy Holder:	Insurance Effective Date:

PERSONAL REPRESENTATIVE AUTHORIZED TO ACCESS PROTECTED HEALTH INFORMATION

Name:	Phone#:	Name2:	Phone#:

1. Financial Responsibility:

I certify that the information I have provided regarding my insurance coverage is correct and I authorize Capital Women's Care to verify insurance coverage and benefits allowed in accordence with my insurance plan's coverage.

I authorize that payments be made directly to Capital Women's Care for all medical insurance benefits which are payable under the terms of my insurance policy for services provided. I agree to pay any copayment, coinsurance, or deductible as required by my insurance for medical care provided to me or my dependant. I understand that I am responsible for knowing the terms and regulations of my insurance plan.

Capital Women's Care may impose a no-show fee of $35.00 for appointments not cancelled 24-hours in advance. Capital Women's Care may impose reasonable interest, late charges, direct collection costs(25%) and or reasonable attorney's fees should my account become delinquent. There will be a $40.00 fee assessed for all returned checks.

2. Payment in full at time of service:

I understand that if Capital Women's Care does not participate with my insurance or I do not have insurance, payment is due in full at the time of service

3. Release of Medical Information for Billing:

I hereby authorize Capital Women's Care to submit a claim and a copy of medical records related to such services, to my insurance company, health and welfare fund, Medicare or Medicaid for medical services provided to me or my dependant. I also authorize Capital Women's Care to provide a copy of this release and a copy of medical records related to such services if requested by the payor. Further, I authorize Capital Women's Care to release medical information to my consulting or primary physician to assit with continuity of care. This release will expire one year from the date of my signature below, unless I cancel this release in writing prior to that date.

4. Receipt of Privacy Notice:

I have been given the opportunity to review the Capital Women's Care Notice of Privacy Practices which provides a detailed description of how my Protected Health Information (PHI) is used and disclosed.

5. Non-Covered Services:

I agree to pay for medical services provided to me or my dependant which are not covered by the benefits in my insurance plan.

I AGREE TO THE ABOVE STATED CONSENT

Signature of Patient or Legal Guardian: **Date:**

CAPITAL WOMEN'S CARE, LLC.

Please update the information below, sign the form, and return the form to the front desk. Thank you.

Patient Information

Name: Account Number: Today's Date:

How did you learn about our practice? ☐ Patient Referral ☐ Other Referral ☐ Website / Internet
☐ Advertising / Radio / TV ☐ Other: _____

Patient Race and Ethnicity (please circle your responses)

Ethnicity: Hispanic/Latino OR Not Hispanic/Latino

Race: Asian, Black or African American, White, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander

Patient Allergies (please include your reaction to each allergy) …the STAFF will enter this into your record

Allergen	Reaction

Patient Medications (please include the dosage for each medication) … the STAFF will enter this into your record

Medications	Dosage

Patient Preferred Pharmacy

Pharmacy Name:

Street Address:

City, State Zipcode:

Pharmacy Phone#:

Email Communications

Capital Women's Care physicians are dedicated to helping our patient's live healthy lifestyles. Your physician would like the opportunity to send patients reminders about preventative health services - such as well women exams - or other information that may assist our patients in living a healthy lifestyle. Also, there may be other messages we would like to send our patients, such as the announcement of new physicians or contract changes with insurance companies.

Capital Women's Care makes this commitment to our patients about the collection of e-mail information.

1. They will be for Capital Women's Care use only. They will not be given or sold to any other entity.
2. The patient's privacy will be protected. The e-mail address will not be used to communicate any personal health information or in any manner inconsistent with the Health Insurance Portability and Accountability Act (HIPAA).

Our e-mailing to our patients will be one way communications and, therefore, will not allow for conversations between the patient and physician/staff. All Health related questions should continue to be addressed to the appropriate Capital Women's Care staff. Additional comments and questions should be directed to the Capital Women's Care Compliance Officer at privacy@cwcare.net<mailto:privacy@cwcare.net> or (301) 340-8339, ext. 201.

Patient Name: (printed) _____

E-Mail Address: _____

Patient Signature: _____

Date: _____