



LISTENING TO YOU. CARING FOR YOU. CLOSE TO YOU.

CONFIDENTIAL PATIENT REGISTRATION

Copies of your insurance cards must be presented and will be copied and verified. A copy of your driver's license is required.

PATIENT INFORMATION

Name: _____ Social Security#: _____

Address: _____ Address 2: _____

City, State, Zip _____

Home Phone # _____ Cell Phone#: _____

Date of Birth: _____ Age: _____ Race: _____

Referring MD: _____ Primary Care MD _____

Marital Status: Married Single Widowed Email: _____

PATIENT EMPLOYMENT

Employer Name: _____ Phone: _____

SPOUSE'S INFORMATION

Name: _____ Social Security#: _____

Date of Birth: _____ Employer Name: _____

EMERGENCY CONTACT(S)

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Would you like information regarding a living will or Power of Attorney? Yes No

Pharmacy of Choice: _____ Address: _____ Phone #: _____

PATIENT AUTHORIZATION

Regardless of your insurance coverage, you as the patient are always responsible for the payment of your charges. A surgical and/or obstetrical deposit may be required if necessary. Our office requires that all co-pays be paid prior to being seen by the provider. Unless you have Medicare, or an insurance our office is contracted with, office charges are to be paid by cash, check or credit card at the time of service. Counselors are available to discuss large dollar charges and payment schedules.

Authorization & Assignment:

I authorize WCG to release any information acquired by my physician/or staff to my insurance carrier(s). I authorize payments directly to my physician. I recognize and accept responsibility for any balance or fees not covered by insurance and agree to pay the balance in a prompt manner. In any event this account is referred to an outside agency, credit reporting bureau or attorney for collection, I agree to pay all attorney fees, collection costs, court costs and/or any other expenses incurred in its collection, according to the 1989 statutes of the State of Tennessee. I authorize WCG to electronically obtain my medication history.

Patient/Responsible Person's Signature: _____ Date _____



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Acknowledgement of Notice of Privacy Practices

I have been given the opportunity to review the Notice of Privacy Practices and understand that the Notice describes how my protected medical information may be used and disclosed and how I may get access to this information. I have also been given the opportunity to take a copy of the Notice of Privacy Practices for further review.

If for some reason the facility needs to relay my protected health information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

- 1. _____
- 2. _____
- 3. _____
- 4. _____

By signing below, I agree to the aforementioned statements.

Patient Name (Printed) _____
Date

Patient Signature (Patient must sign regardless of age) _____
Account Number/Chart Number

Patient Disclosure and Agreement

Your insurance contract will not cover more than one of the following visits per day. These visits cannot be combined. If you have more than one of the following we will be happy to schedule an appointment specifically for that reason for another day. This also helps our office respect your time and other patients' time by staying on schedule.

Indicate only one of the following:

- Annual Gynecologic Examination** (breast and pelvic exams, Pap smear, prescription refills)
- Problem Visit or Follow-Up Examination** (bleeding problems, infections, pain, hormonal problems, menopause, surgery scheduling, contraception counseling, follow-up Pap smear, post partum, post operative, etc.)
- Consultation for a Second Opinion or Consultation from a Referring Physician**

If you are scheduled for the following, please indicate which one(s). Insurance contracts allow these tests to be performed on the same day as one of the above visits or on a separate day.

- Lab Tests/Injection** • **Bone Density (DEXA)** • **Pelvic Ultrasound** • **Urodynamics**

Indicate what your insurance contract covers: annual gynecologic examinations • visits by a gynecological specialist • consultations by a gynecological specialist • diagnostic tests • No coverage, but I want to be seen for the above indication anyway. • I know I may be responsible financially for these expenses.

Patient/Responsible Person's Signature: _____ **Date:** _____