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#: _____ Race: _____

Address 1 :_____ Home Phone #: _____

Address 2: _____ Cell Phone#: _____ Date of Birth: _____

City, State, Zip _____ Age:_____

Referring MD: _____ Primary Care MD:_____

Marital Status [ ] Married [ ] Single [ ] Widowed E-Mail: _____

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 statues of the State of Tennessee. I authorize WCG to electronically obtain my medication history.

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

Acknowledgement of Notice of Privacy Practices/ Patient Authorization

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 fore mentioned 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 patient's time by staying on schedule.

Indicate only one of the following:

_____ **Annual Gynecologic Examination** (breast and pelvic exams, Pap smear, prescription refills)
_____ **Problem 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** _____ **Problem visits by a gynecological specialist** ____**Consultations by 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:**_____