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.

WOMEN'S CARE GROUP

PATIENT INFORMATION

Name:________________________________Social Security #:________________Race:___________

Address 1:____Home Phone #:______________

Cell Phone:____Date of Birth:_______________

City, State Zip:____Age:_____

Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed [ ]Partnered

Pharmacy of Choice:_______________________Address:______Phone:_________

PATIENT EMPLOYMENT

Employer Name:____________________________Phone:______________

SPOUSE'S INFORMATION

Name:__________________________________Social Security #:__________________Date of Birth:_______

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.
The collected information is stored in the practice electronic medical record system. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.
Over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.
I give my permission to allow Women's Care Group, PLLC to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Signature of Patient: ____ Chart #___________________

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled out at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Patient Authorization

Regardless of your insurance coverage, you the patient are always responsible for the payment of your charges. A surgical or obstetrical deposit may be required if necessary. Our office requires copays and deposits at the time of services. Office charges, such as copays and deposits, can be paid by cash, check, or credit card.
By supplying my home phone number, mobile number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary.

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 other expenses incurred in this collection according to the 1989 statutes of the State of Tennessee. I authorize WCG to electronically obtain my medication history.

Patient or Responsible Person's Signature:_______________________________Date:_______________________

CONFIDENTIAL PATIENT REGISTRATION

Acknowledgement of Notice of Privacy Practices/ Patient Authorization

Patient Name: ___________________________________ Date: _________________ Chart #: _____________

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 understand that if I request a copy of the Notice of Privacy Practices, one will be provided to me. By supplying my home phone number, mobile phone number, email, address, and any other personal contact information, I authorize my health care provider to contact me or to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary. I authorize my health care provider or its agents to call my cell phone either manually or by auto dialer to collect any amount I owe. I understand that if any fees are incurred in the collection of my account, I will be responsible for any interest, court costs, and reasonable attorney's fee allowed by Tennessee law. If for some reason the facility needs to relay my health information, i.e., lab results or billing issues, you can either leave a message or discuss the information with the following individual(s):

____ ____

Name and Relationship Name and Relationship

By signing below, I agree to the statements above:

____ _______________________________

Patient Signature (patient must sign regardless of age) Date

I give permission to the physicians and their staff at Women's Care Group, PLLC to leave messages regarding my healthcare in the following manner when I am not available:

Contact information:

I prefer to be contacted through the Patient Portal, **(the quickest, most convenient way to receive information)**:
YES_____ NO_____

*If YES, please note your email address: ____________________________________

*If we need to call you with urgent results, please provide the best number to contact you:

____

___May leave results.

___May leave a message with call back number only.

If no to the above options, allow 10-14 business days or longer for results to be mailed to you

Urgent or Emergencies:

Permission to call your contact number or emergency contact number if we need to reach you for an urgent or emergent matter:

Emergency Contact(s):

Name: ________________________ Number: ___________________ Relationship: ________________

___May leave results.

___May leave a message with call back number only.

Signature of Patient: _____________________________________ Date: ________________________

270 BMH Physician Office Building
Maryville, TN 37804
P. (865) 546-1642
F. (833) 396-2528

Late, Cancellation, and No-Show Appointment Patient Policy

Dear Patient,

We sincerely appreciate that you have chosen a provider with Women's Care Group, PLLC to participate in providing you with comprehensive and quality healthcare. We ask for your help in accomplishing this goal for all our patients by following the practice guidelines below:

1. **Cancellation of the Provider Appointment**
   Providers request a minimum of 24 hours in advance to cancel an appointment.

2. **Late Arrival for Provider Appointments**
   We ask that you arrive 15 minutes prior to your actual appointment time. This allows time for the registration process. We understand that delays can happen and arriving late may prevent you from being seen by the physician. If you arrive more than **five minutes** late for your appointment time, it will be determined by the physician if he/she can fit you into the schedule at that time, or you may be requested to reschedule.

3. **No Show for Provider Appointments**
   A "no show" appointment is when you do not call to cancel or reschedule your appointment.

FOR NEW PATIENTS: If you are habitually late to your appointments or have 3 **"NO SHOW"** appointments we will not be able to reschedule you for future appointments.

FOR ESTABLISHED PATIENTS: If you are habitually late to your appointments or have 3 **"NO SHOW"** appointments in a year, you will receive a warning letter regarding the missed appointments. After warning letter, if further appointments are No Showed, we may dismiss you from our practice.

Sincerely,

Women's Care Group, PLLC

By signing this letter, I understand and agree to the terms stated herein:

Patient Signature: ____ Date: _________________________

Print Name: ____ Chart Number: ________________________