Patient Registration Form

Today's Date: ___ /___ /_____
Last Name:______________________________ First Name:______________________ Middle:________
Address:__________________________________APT#________________________________
City______________________________________ State:_____________ Zip_____________
Home Ph: (_____) _______________ Work Ph: (_____) _______________ Other Ph: (_____)_______________
SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: _____ / _____ / _____ Age:________
Status: Single Married Widow Divorced Sex: Male Female Occupation:____________________
Employer: ____________________________ Employer Phone:(_____) _______________
Emergency Contact Person: ______________________________ Phone: (_____) _______________
Email: ____

Insurance Information

(If insurance information is incorrect or incomplete, the patient will be responsible for bill)

Primary Insurance Name:______________________________Phone: (_____) _______________
Address: ____________________________ City/State ________________________ Zip___________
Subscriber Name:______________________________ Employer:____________________
SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: ____ / ____ / ____ Relationship to patient__________
ID#:____ Group #:____________________

Secondary Insurance Name:______________________________Phone: (_____) _______________
Address: ____________________________ City/State ________________________ Zip___________
Subscriber Name:______________________________ Employer:____________________
SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: ____ / ____ / ____ Relationship to patient__________
ID#:____ Group #:____________________

Guarantor Information (patients age 18 and under)

Last Name:__________________________ First Name:______________________ Middle:__________
Address:__________________________________APT#____________________________
City______________________________________ State:_____________ Zip_____________
Home Ph: (_____) ____________________ Relationship to Patient:______________________________
SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth: _____ / _____ / _____
Status: Single Married Widow Divorced Sex: Male Female Occupation:____________________
Employer: ____________________________ Employer Phone:(_____) _______________
Parent / Guardian Signature if Patient is Under 18: ____

Consent/Release/Authorization

The insurance information listed on page one is current and correct. If any information is incorrect, I understand that I will be held responsible for any unpaid balance. I also understand and I agree that I will be responsible for any collection or legal fees associated with the collection of overdue balances that are my responsibility. It is my responsibility to notify Healthy Woman of any changes that occur in my insurance coverage.

I authorize Healthy Woman to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payment for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance. In order to evaluate my present health status, I hereby consent, voluntarily, to undergo examination and necessary treatment by Healthy Woman. I authorize Healthy Woman to disclose my health information for treatment, payment and health care operations. I have read and understand the above and hereby, voluntarily give my consent and authorization.

Patient Signature____ Date _____ / _____ / _____

How did you hear about our practice? ____________________

Primary Care Physician's information: Name: ____________________

Address: ____________________

Phone: ____________________ Group Name: ____________________

Medical Problems: (chronic or serious illness, past or present) ____________________

Past surgeries or hospitalizations: ____________________

____

____

Medications you are presently taking:

____

____

List Allergies:

Allergies to Medication: ____________________

Other allergies (food, seasonal, etc.) ____________________

Ob/Gyn History:

Date of your last menstrual period: _____ / _____ / _____ Menstrual Problems? ____________________

Number of Deliveries ____________________ Miscarriages: ____________________

Social History:

Do you use tobacco now?: __________ In the past?: __________ How much?: __________

Do you use alcoholic beverages?: __________ Weekly amount?: __________

Family History:

Yes	No	Diabetes	Yes	No	Tuberculosis
Yes	No	Kidney Disease	Yes	No	Cancer Type: __________
Yes	No	Heart Disease	Yes	No	Skin Disorder
Yes	No	Stroke	Yes	No	Glaucoma
Yes	No	High Blood Pressure	Yes	No	Thyroid Disorder

Present Complaint:

____

____

____

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312 Professional View Drive
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Ph: (732) 431 – 1616
Fax: (732) 866 - 7962

Colts Neck
340 Highway 34
Suite D-2
Colts Neck, NJ 07722
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Authorization for Release of Protected Health Information

I authorize the staff and/or physicians at Healthy Woman to discuss my healthcare, diagnosis, test results, procedures, prognosis, insurance and billing information with the following person(s) for the purpose of my treatment or payment of services rendered *:

____________________ ____________________
Name of designated person — Relationship to patient

____________________ ____________________
Name of designated person — Relationship to patient

☐ **I DO NOT wish to designate any person(s) ***

Please note for children under 18 years of age, information will be released to the parent or legal guardian.

I authorize the release of my Protected Health Information to the following physician(s) or facility(s) upon request of the physician(s) or facility(s) for the purpose of my treatment:

____________________ ____________________
Name of designated Physician or Facility — Type of Physician or Facility

____________________ ____________________
Name of designated Physician or Facility — Type of Physician or Facility

☐ **I DO NOT wish to designate any physician(s) or facility(s)**

I understand that in order to ensure continuation of care, the staff and/or physicians at Healthy Woman may need to leave messages on the answering machine at my home or with any individual(s) who may answer my home phone. These messages may include but are not limited to: appointment confirmations, lab results, radiology results, pathology results, etc.

☐ **I DO wish to have messages left** ☐ **I DO NOT wish to have messages left**
☐ **I DO NOT wish to have email sent**

I also understand that by designating the above individual(s) or facility(s), I am allowing my Protected Health Information (medical records/ information) to be discussed or released to them. I know that this is my personal choice and I have not been forced to designate any individual(s) or facility(s) if I have chosen not to.

____________________ X____________________
Patient Printed Name — Patient Signature

___/___/____
Date

Privacy Practices Acknowledgement

I have reviewed / received the Notice of Privacy Practices for Healthy Woman

____________________ X____________________
Patient Printed Name — Patient Signature

___/___/____
Date

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Medical Services Waiver

I understand that I am presenting myself in the office today for medical services to be performed. While many insurance companies cover the services that may be performed such as an annual exam (including pap smear, breast exam, other age appropriate screenings), biopsies, colposcopies and injections, I have been informed that some insurance companies do not. If my insurance company does not pay Healthy Woman for the services performed today I understand that any charges incurred during my exam will be my financial responsibility.

I understand that I will also be responsible for any copay or coinsurance payment due to Healthy Woman at the time of service, per the requirements of my health insurance plan contract.

I also understand that I will be responsible for payment of charges in full if I do not have any health insurance coverage.

Lastly, I understand that if I require a referral or preauthorization for Healthy Woman's services or any additional services recommended by Healthy Woman (including but not limited to radiology and lab work), I am responsible for either obtaining the correct referral OR notifying the office within 48 hours of the date of service to obtain an authorization. If I fail to do so, I will be responsible for the balances billed by Healthy Woman or outside parties for these services.

X ______________________________ ______________________________

Patient Signature Patient Printed Name

If patient is under 18:

X ______________________________ ______________________________

Parent / Guardian Signature Patient Printed Name

____/____/______

Date

Patient Name: ______________________ Phone: ______________________

Email: ______________________ Age: ________________

Health Questionnaire

MENSTRUAL CYCLE

1. Do you experience heavy periods? ☐Yes ☐No

If you are done having children, you may be a great candidate for cryoablation, a 12- minute procedure (no pain or recovery time) done right here in our office. Ninety (90%) percent of woman who have had a cryoablation experience a lighter cycle post- procedure. Would you like your doctor to tell you more about it?

☐Yes ☐No

HEALTH &FITNESS

1. Are you happy with your weight? ☐Yes ☐No

2. Can we contact you about our medically-supervised, personalized weight loss program that has already helped lose over 30,000 pounds-and keep it off?

☐Yes ☐No

BEST PART? You can safely lose up to 20 pounds in one month.

(A) **Notifier(s):**

(B) **Patient Name:** *(C)* **Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for *(D)*____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the *(D)*____________ below.

*(D)*____________	*(E)* Reason Medicare May Not Pay:	*(F)* Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the *(D)*____________ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

***(G)* OPTIONS:** **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the *(D)*_________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the *(D)*_________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the *(D)*_________ listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

(H) **Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	*(J)* Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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Records Release Authority

Records to Healthy Woman OB/GYN

To Dr:______________________________
____
____
____

I, ________________hereby request that you release a complete copy of my medical records to:

Healthy Woman
PO Box 6339
Freehold, NJ 07728

Date of Request ____/____/______ Patient Signature ______________________

Date _____/_____/_______ Witness Signature ______________________

Patient Address ______________________
City, State, Zip ______________________

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