REGISTRATION FORM

Today's Date:				
PCP:		Email:		
PATIENT INFORMATION				
Patient's Last name: First:		Middle:		Marital status:
Race:	Ethnicity:	Birth date:	Age:	Sex: ○ M ○ F
Address:				
Social Security no.:	Home phone no.:	Cell phone no.:		
Occupation:	Employer/School:	Employer phone no.:		
INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Person responsible for account:	Subscriber's name:	Birthdate:	Address (if different):	
Primary insurance:		Secondary insurance:		
Policy/ID no.:	Group no.:	Policy/ID no.:	Group no.:	
Patient's relationship to subscriber:				
IN CASE OF EMERGENCY				
Name:	Relationship to patient:	Home phone no.:	Work phone no.:	

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to ***Carolina Women's Physicians P.A.*** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor/facility may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient/Guardian signature _____ Date _____

2414 Emerald Place Greenville, NC 27834 Telephone# 252-355-7805 Fax# 252-758-2970

Payment Policy

The undersigned hereby agrees to reimburse Carolina Women's Physicians, PA directly for any services and/or supplies provided to the patient.

If the patient's insurance company has not paid within 90 days of billing, the patient is responsible for the balance in full. Balances owed after insurance has been billed are due within 30 days unless other arrangements have been made through our office separate agreement has been signed.

Please note: Insurance is filled as a courtesy for our patients benefit. The patient/guarantor is still responsible for all charges and payments. Any benefits quoted are estimates and should not be taken as a guarantee for insurance payment.

Patients without insurance are expected to pay in full at the time services are rendered. Payment is required unless arrangements have been made through our office and a separate agreement has been signed. The patient/guarantor understands that all amounts quoted are estimates and additional charges may incur during treatment and testing.

Unless otherwise instructed, we send all pap smears to an outside pathology lab to be read by a pathologist. We send other labs to a third-party in-house laboratory. The patient may receive a bill from these facilities.
All insured patients must present their current eligibility cards and pay all co-pays/co-insurance fees at time of check in.

For our practice to maintain efficiency in the Operating Room, as well as giving full consideration to the hospital, anesthesia, and office staff, it is necessary for us to implement the following cancellation policy. It is important that when you schedule your surgery/procedure you have thoroughly checked your personal calendar to ensure that your scheduled date is ideal for you. Cancelling or rescheduling your surgery/procedure requires multiple phone calls to the hospital/outpatient facility, insurance companies, and patients.

Office Fees:

- Office Visit/Nurse Visit: fee determined by patient's insurance
- Duplicate/Lost prescriptions: $25
- Forms/FMLA/Medical Records: $25
- Non-emergent After hour calls: $25
- No Show/Late Cancellation Fee: $75 *We understand that an emergency may necessitate a late (or same day) cancellation. If this occurs, the patient may no be charged a fee.
- Late Surgery Cancellation Fee: $100 (Please note: Cancellation less than two weeks before surgery will result in this. This fee will not be applied towards your surgery procedure, will be added as a charge to your account, not billable to insurance. This fee must be paid to Carolina Women's Physicians in order to be rescheduled.)
- Surgery/Procedure No Show Fee: $300 (please note that this fee is not billable to insurance)

The undersigned has read and certifies that they are the patient, the patient's legal representative, or are the duly authorized by the patient as the patient's general agent to execute this consent to pay for the services and accept its terms.

_____ _____

Patient/Guardian Signature Date

CAROLINA WOMEN'S PHYSICIANS, P.A.
2414 Emerald Place
Greenville, NC 27834
Phone: (252) 355-7805
Fax: (252) 758-2970

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize (Name of Facility, Address, Phone, and Fax Number of Facility *Requesting Records From*)

_____

_____

_____

To disclose a copy of health information to (Name of Facility/Person, Address, Phone, and Fax Number)

Carolina Women's Physicians, P.A.
2414 Emerald Place
Greenville, NC 27834

On the following patient:

_____

(Name) (Date of Birth) (Social Security Number)

The information to be disclosed shall be: (Please check)

- □ All records
- □ Labs
- □ Mammogram
- □ Pap Smear
- □ Pathology
- □ Physical Exams/Office Visits
- □ Prenatal
- □ Surgery
- □ Other (Specify) _____

I understand this information will include records relating to:
Alcohol and/or Drug Dependency
HIV Antibody Test and Diagnosis/Treatment
Mental Health Treatment

This Disclosure is being made for the following purpose: (Please check)

- □ Continuing Care
- □ Insurance
- □ Moving
- □ Transfer Care

I understand that the information released cannot be re disclosed. I also understand that the facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Signature of Patient/Guardian/Legal Representative Date

_____

Witness Date

For Office Use Only

Acknowledgement of Receipt of HIPAA Privacy Notice

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices for Carolina Women's Physicians, PA. _____

Release of Billing Information and Assignment of Benefits

I authorize Carolina Women's Physicians to bill my insurance. _____

I authorize the assignment of benefits from my insurance to Carolina Women's Physicians. _____

Medication History Authority

I give authorization to Carolina Women's to access my medication history for continuity of care. _____

_____ _____

Patient Signature Date

Carolina Women's Physicians, PA

Dr. Jennifer Ferguson
Sarah Miller, FNP

Medicaid Policy

Effective 03/15/2012

- Carolina Women's Physicians does not accept Medicaid for obstetrical services
- Carolina Women's Physicians does not accept Medicaid as a secondary carrier for either obstetrical or gynecological services
- Carolina Women's Physicians does not accept Medicaid as a primary carrier for gynecological services

I understand the above policy regarding Medicaid, and I am aware that I will be financially responsible for any balance on my account not paid for by my insurance carriers. Carolina Women's Physicians will not be filing Medicaid as a secondary carrier for professional services that I receive.

_____ _____

Patient Signature Date

_____ _____

Witness Date