Patient Information Registration Form

Patient's Full Name: _____Age:_____ DOB _____
Address: _____
City: _____State: _____ Zip: _____
Home Phone: _____Cell Phone: _____email: _____
Social Security Number: _____ Occupation: _____
Patient's Employer: _____Work Phone No: _____
Circle One: Married / Single / Divorced / Separated / Widowed
Race: _____ Ethnicity: Non-Hispanic Hispanic Language Spoken: _____
Emergency Contact: _____ Phone_____ Relationship: _____

INSURANCE INFORMATION:

Primary Coverage, Name of Carrier:
_____
Group No: _____
Identification No _____
Subscriber: _____
DOB_____SS#_____
Phone # _____

Secondary Coverage, Name of Carrier:
_____
Group No:_____
Identification No_____
Subscriber: _____
DOB_____SS#_____
Phone # _____

Address(if different from patient): _____

Preferred pharmacy: _____Address:_____Phone_____
I authorize the release of my prescription history to GYN Associates of Fredericksburg: Y N

We ask all patients to show their insurance or managed care membership card so that we may make copies of them. Your insurance coverage is a contract between you and your insurance company. This medical office will cooperate in processing your claim; however, **you are ultimately responsible for payment of your account**. You may receive a statement each month from the billing office of Gynecology Associates of Fredericksburg even though you have an insurance claim pending. The statement will list all charges, payments, adjustments made during the prior month, and will show the current balance. You will be charged a $50.00 fee for any check returned for nonpayment. Please include your account number on all payments and on all correspondence. Patients are responsible for notifying the office about any appointment time changes or cancellations at least 24 hours before the appointment time. There is a $50.00 charge for late cancellation or missed appointments.

Patient Authorization: I hereby authorize Gynecology Associates of Fredericksburg to release to my insurance company any medical information and/or other information on this form as may be necessary for the process of claims. I hereby authorize payment directly to Gynecology Associates of Fredericksburg for any benefits payable to me by my insurance company for services and costs in connection with Gynecology Associates of Fredericksburg. I understand that I am responsible for full payment of all charges incurred with the services provided and agree to make full payment for such charges by cash, credit card, check and/or by payment from assigned insurance benefits. I understand that all charges not covered by insurance are due in full at the time services are rendered. In the event that full payment for charges incurred in connection with the services rendered are not made as agreed upon above, I agree to pay a delayed payment fee at the rate of 1.5% per month 18% per year on the unpaid balance and to pay all expenses incurred in collection of any said charges, including reasonable attorney's fees. I agree to the late cancellation or missed appointment fee.

_____ _____
Signature **Date**