



PATIENT REGISTRATION FOR WOMEN'S HEALTH WISE

Patient Name (Legal Name): _____ Date: _____

Address: _____ City/St/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SS#: _____ Birth Date: _____ Marital Status: _____

Preferred Pharmacy: _____ Location: _____

Employer: _____ Occupation: _____

Address: _____ City/St/Zip: _____

Emergency Contact: _____ Relationship: _____ Contact Phone: _____

Primary Care Physician: _____ Referred By (Dr, friend, etc.) _____

If patient is under 21 please fill in the following blanks

Parent/Guardian Name: _____ Phone #: _____

Address (if different from pt): _____ Relationship: _____

Employer's Name: _____ Phone #: _____

Please Read the Following Disclosure Carefully Before Signing

I hereby assign to Women's Health Wise all monies to which I am entitled for medical and/or surgical expenses relative to the service rendered by this practice, but not to exceed my indebtedness FULLY to said medical practice. It is understood that any monies received from my insurance company (named on the insurance form), over and above my indebtedness, will be refunded to me or my insurance company(s), as is determined to be appropriate, when my bill is paid in full.

I understand I am financially responsible to Women's Health Wise for charges not covered by this assignment. A service charge of 1.75% per month (21% APR) will be added to unpaid accounts after 30 days. In the event I default, I agree to pay, whether or not legal proceedings are instituted, a reasonable COLLECTION FEE which shall be the greater of \$30 or 30% of the principal balance for any debt incurred hereafter and to pay all reasonable LEGAL COSTS as a result of my default.

I UNDERSTAND THAT ALL COPAYS AND DEDUCTIBLE AMOUNTS WILL BE DUE AT THE TIME OF SERVICE AND WILL NOT BE BILLED TO ME UNLESS PRIOR ARRANGEMENTS HAVE BEEN ESTABLISHED.

Signature of Patient/Responsible Party: _____

Although we are happy to send insurance claims on your behalf, full payment for services is ultimately the responsibility of the Patient/Responsible Party.