

WOMEN'S HEALTHCARE ASSOCIATES OF REDDING

PATIENT REGISTRATION INFORMATION

****PLEASE PRINT AND COMPLETE ALL SECTIONS BELOW****

Today's Date _____
Patient Name _____ Date of Birth _____ S.S.# _____
Mailing Address _____ City, State and Zip Code _____
Home Phone# _____ Work Phone# _____ Cell Phone# _____
Occupation _____ Marital Status: M S D Sep W Partner Language _____
Race/Nationality: Caucasian / African American / Hispanic / Asian / American Indian / Other _____
How did you hear about us? _____ Who is your primary care doctor? _____

INSURANCE AND BILLING INFORMATION

(OFFICE CO-PAYMENT IS REQUIRED AT THE TIME OF CHECK-IN)

PRIMARY

INSURANCE COMPANY _____ ID# _____ GROUP# _____
OFFICE CO-PAY \$ _____ NAME OF INSURED _____ DOB _____
RELATIONSHIP TO PATIENT: SELF / SPOUSE / PARENT / OTHER _____
INSURED'S EMPLOYER _____

SECONDARY

INSURANCE COMPANY _____ ID# _____ GROUP# _____
OFFICE CO-PAY \$ _____ NAME OF INSURED _____ DOB _____
RELATIONSHIP TO PATIENT: SELF / SPOUSE / PARENT / OTHER _____
INSURED'S EMPLOYER _____

ASSIGNMENT OF INSURANCE INFORMATION

I hereby authorize direct payment of medical/surgical benefits to Women's Healthcare Associates of Redding for services rendered. I understand that I am financially responsible for all charges incurred whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Women's Healthcare Associates of Redding to release any medical or incidental information that may be necessary to secure the payment of benefits.

CONTACT INFORMATION AND INSURANCE CERTIFICATION

I certify that the information given by me in applying for payment is correct. I authorize release of all records upon request. I request that payment of authorized benefits be made on my behalf. I further agree that a photocopy of these assignments shall be as valid as the original.
I agree to be responsible for any costs associated with collection of funds owed to the practice, including but not limited to, collection agency fees, attorneys' fees, and court costs.

Patient / Parent / Guardian – (PLEASE PRINT)

SIGNATURE

DATE