Sandhills Womancare, PA
1367 Walter Reed Rd., Suite 101
Fayetteville, NC 28304
Phone: 910 486-7006

PATIENT INFORMATION

DATE: Registration Form

Patient name:

Address:

City, State, Zip:

Home Phone Number: Work Phone Number:

Date of birth: Social Security Number:

Employer_____ occupation_____

Employer address_____

City_____ State_____ zip_____

SPOUSE INFORMATION (OR IF MINOR CHILD, RESPONSIBLE PARTY'S INFORMATION)

Last name_____First name_____MI_____

Data of birth_____ Social security number_____

Employer_____ occupation_____

Employer address_____

City_____ State_____ Zip_____

CONTACT INFORMATION

Emergency contact:

Emergency phone:

PAYMENT INFORMATION

I will be paying by_____ cash_____ check_____ Credit card

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

I hereby authorized the release of any medical information necessary to process my insurance claim. I have read all the information on the sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify the office of any changes in my health status or in the above information.

_____ _____

Signature (Parent/Guardian – if minor child) Date

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HIPAA Privacy Rights

1. Please list the family members or other persons, if any, whom we may inform about your general medical conditions and your diagnosis:

2. Please list the family members or significant other(s), if any, whom we may inform about your medical condition(s) ONLY IN EMERGENCY:
   a. Name_____ phone #_____
   b. Name_____ phone #_____
3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home:
   _____
4. Indicate if you want all your correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": Yes_____ No_____
5. Please print the telephone number where you want to receive calls about your appointment, lab, diagnostic tests result and reports, or other healthcare information if other than your home phone number: _____
   "I am fully aware that a cell phone is not a secure and private line"

6. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? Yes_____ No_____
7. I have been given the opportunity to read or obtain a copy of my Patient's Rights and Responsibilities: Yes _____
8. I have been given the opportunity to read or obtain a copy of the Joint Notice of Privacy Practices: Yes _____
9. Advanced Directives Yes_____ No_____
   Do you have a Health Care Power of Attorney? Yes_____ No_____
   Living Will? Yes_____ No_____
   Have you supplied us with a copy? Yes_____ No_____

Patient or Guardian Signature_____ Date _____

Account number:

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any further treatment. All patients must complete our Patient Registration form and HIPAA Statement of Understanding, as well as provide proof of insurance coverage prior to being evaluated by the physician. Failure to provide proof of insurance will result in patient being treated as a self-pay patient with payment required in full at the time of service.

WE WILL FILE CLAIMS FOR THE SERVICES RENDERED TO YOUR INSURANCE CARRIER; HOWEVER, YOUR PORTION OF THE BILL IS DUE AT THE TIME THE SERVICE IS RENDERED.

WE ACCEPT CASH, CHECKS OR DEBIT/VISA/MASTERCARD.

INSURANCE:

You are responsible for providing us with your correct insurance information before services are rendered. Failure to provide us with your most recent Insurance information may result in your claim being denied and balances being transferred to you. This is especially true if your claim is not filed within a 90-day period from date of service because incorrect insurance information is on file. Providing our office with new or changes in insurance information is the patient's responsibility. Without this information, you will be asked to reschedule the appointment until you have all the necessary information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will accept assignment of benefits for all insurance that we contracted with. If you have a policy that pays to the patient only, the patient will be responsible for filing. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us correct insurance information. If your insurance company has not paid their portion of your claim within sixty (60) days, the balance will be transferred to your responsibility. Please be aware that some, or perhaps ALL of the services provided may be considered non-covered services and are not considered reasonable and necessary under the Medicare program and/other private pay sources.

MISSED APPOINTMENTS:

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointment at the rate of $50 dollars per visit. Three missed appointments constitute grounds for dismissal from the practice. After three missed appointments, it will be left up to the physician as to whether or not you will be discharged from the practice. Please help us serve you better by keeping your scheduled appointments.

COLLECTIONS:
Should your account be turned over to collections, no further care will be provided until the balance has been paid in full.

PAYMENT ARRANGEMENTS:
If you are an established patient with six months or more of care with us and you have a good payment history with us, payment arrangements are available, if you are unable to pay your bill in full. A payment arrangement requires that you put half down with the remaining balance paid over a 90-day period. This may vary depending on the circumstances. You may speak with our insurance coordinator for more information.

PATIENT OVERPAYMENT/REFUNDS:
If there is an overpayment on your account, you may request a refund. We will automatically process an overpayment of $50 or more. If it is under $50, it will stay on the account as a credit that will be applied to future visits unless otherwise requested by the patient. We ask that you allow 30 days for all refund requests.

MEDICAL RECORDS:
If at any time, you are in need of obtaining your medical records, our policy is that you allow us 3 to 5 days to process your request. A properly signed medical release form is required before any records can be released. Depending on how large your records are, there will be a cost incurred for all medical records. The cost may exceed $25 depending on the volume of records requested.

CHILDREN:
Because of limited space and distractions that may occur, **UNDER NO CIRCUMSTANCES**, are children allowed beyond the waiting area ….. They **ARE NOT** allowed in exam rooms. **THERE ARE NO EXCEPTIONS**.

Thank you for taking the time to read our financial policy. Please let us know if you have any further questions.

I have read and understand the financial policy:

Name _____ Signature_____

Date_____