



## New Patient Registration Form

General Information (please print)		
Name: _____	DOB _____	Sex: __M __F
Social sec # _____	Marital status: Single__ Married__ Divorced __Widowed __	
Primary address _____		
City _____	State _____	Zip _____
Home phone _____	Work phone _____	Cell phone _____
Emergency contact _____	Relationship _____	Phone _____
E-mail _____	Authorize E-mail? __Y __N	
Pharmacy name _____	Phone _____	Fax _____
Employment status: __employed __not employed __retired __student		
Employer: _____	Occupation _____	

Patient Phone Message Consent		
It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you authorize us to:		
<input type="checkbox"/> Leave a detailed message on voice mail/machine/cell	YES _____	NO _____ (initial yes or no)
<input type="checkbox"/> Leave a detailed message with individual answering the phone	YES _____	NO _____ (initial yes or no)

Sharing of Medical Information	
I give the physician and office staff of <b>WWMH</b> permission to discuss my medical condition with the following individuals:	
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

Doctor Information	
Referring Physician _____	Specialty _____
Primary Care Physician _____	Phone _____

Primary Insurance	
Insurance name _____	Subscriber's name _____
Insurance ID#: _____	
Social Sec # _____	DOB _____ Relationship to insured _____

Secondary Insurance	
Insurance name _____	Subscriber's name _____
Insurance ID#: _____	
Social Sec # _____	DOB _____ Relationship to insured _____

**Patient Authorization for ePRESCRIBE**

ePrescribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of **WWMH** to enroll me in the ePrescribe Program. .

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**Patient Authorization for PHARMACY BENEFITS MANAGER**

I authorize the physician and/or staff of **WWMH** to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third party pharmacy payors for treatment purposes.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**Patient Authorization for MEDICARE PATIENTS**

I authorize the physician and/or staff of **WWMH** to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**Patient Authorization for PPO and HMO PATIENTS**

I authorize the physician and/or staff of **WWMH** to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to Westchester Women's Medical Healthcare the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**Patient Authorization for ALL PATIENTS**

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and **WWMH** to photograph me for medically related documentation purposes.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**Special Accommodations**

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify **WWMH** of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by **WWMH** is the patient's responsibilities.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish. ***I acknowledge that I have received a copy of the WWMH'S Notice of Privacy Practices.***

Printed name \_\_\_\_\_

Signature \_\_\_\_\_

Date signed \_\_\_\_\_