R-P-W Obstetrics & Gynecology, S.C.
Registration Information
****THIS MUST BE FULLY COMPLETED – FRONT & BACK****

Patient Name_____ Home Phone_____
Cell Phone_____
Age_____ Birthdate_____ Social Security #_____
Maiden Name_____ Drivers Lic#_____
Street Address_____
City_____ State_____ Zip Code_____
Single____ Married_____ Widowed_____ Separated____ Divorced_____
Employer_____
Address_____
Work Phone_____ Occupation_____

Primary Care Doctor_____
Address_____ Phone_____

Guarantor Information
Name_____Relationship_____
Address (if different than above)_____
_____
Social Security #_____Birthdate_____
Employer_____
Address_____
Work Phone_____ Occupation_____

Insurance Information
Do you have Medical Insurance? Yes_____ No___ If Yes, please present card to receptionist.
Do you have maternity coverage? Yes_____ No___
Primary Insurance Company_____
Copay$_____ Is this a PPO_____ POS_____ HMO_____
Claim Address_____
Policy Holders Name_____Birthdate_____
ID#_____ Group #_____
Secondary Insurance Company_____
Is this a PPO_____ POS_____ HMO_____
Claim Address_____
Policy Holders Name_____Birthdate_____
ID#_____ Group #_____

Nearest relative or friend not residing with your that we can contact in case of emergency:
Name_____ Relationship_____
Phone_____

Referred to our practice by:
Physician (name)_____
Relative/Friend (name)_____
Insurance Company_____
Other_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to R.P.W. Obstetrics & Gynecology, S.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made directly to R.P.W. Obstetrics & Gynecology, S.C. for any services furnished by the physicians of R.P.W. Obstetrics & Gynecology, S.C. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized release of the information to the Insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

OFFICE POLICY ON MANAGED CARE INSURERS

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed.

Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated. It is your responsibility to be familiar with the specific rules of your own plan.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance guidelines if you let us know at EACH time of service exactly what those guidelines are. Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility, as are any copays.

I have read and understand the office policy on managed care insurers. I agree that if I do not adhere to the provisions of my managed care plan, that I will be responsible for any charges incurred.

_____ _____

Signature Date