Creekside Center for Women

5330 Willow Creek Drive
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REGISTRATION INFORMATION

Date_____

Last Name _____ First Name _____ Middle Initial _____
Mailing Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____ Social Security Number _____
(circle one) Married Single Divorced Widowed E-mail _____

Race (circle one) American Indian/Alaska Native Asian Black/African American Nat Hawaiian/Pacific Islander
White Other Race Decline

Ethnicity (circle one) Hispanic/Latino Not Hispanic/Latino Decline

Patient's Employer _____ Phone _____
Address _____
City _____ State _____ Zip Code _____
Spouse or Responsible Party's Name _____
Date of Birth _____ Social Security Number _____
Address _____
City _____ State _____ Zip Code _____
Employer _____ Phone _____
Emergency Contact _____ Relationship to Patient _____ Phone _____
Referred by name: _____
(circle one) Family Friend Yellow Pages Patient Physician or Hospital
Do you have Insurance Yes No Private Contract or Employer Contract
Is Your Insurance through Self Spouse Parent
Primary Insurance Info _____
Group #_____ ID# _____
Secondary Insurance Info _____
Group #_____ ID# _____

Pharmacy Name _____ Phone _____
Family Doctor _____

ASSIGNMENT AND RELEASE

I,the undersigned, have insurance coverage with _____
And assign directly to Creekside Center for Women, 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 payment of benefits, to include obtaining a copy of my credit report as needed. I authorize the use of this signature on all my insurance submissions. I authorize the doctor to securely access my prescription history from community pharmacies, payers and pharmacy benefits managers.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Creekside Center for Women any services furnished me by that physician. 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 as well as obtaining a copy of my credit report in order to conduct daily operations if needed. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing 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 non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Insured or Beneficiary Date