Physicians & Surgeons
for Women

1821 E. High St., Springfield, Ohio 45505 and

900 Scioto St., Suite 6, Urbana, Ohio 43078
Phone (937) 323-7340 Fax (937) 323-3363

REGISTRATION FORM

Patient Information

Last Name	First Name	MI	Date of Birth	SS #	
Street Address		City		State	Zip
Home Phone	Work Phone	Cell Phone		Marital Status	
Email	Relationship to Responsible Party			Race _Caucasian _ Black _Hispanic _ Other	
Employer	Employers Address	City		State/Zip	
Referring Physician	Address			Phone	
Pharmacy Name	Phone	Address			

Responsible Party: (If different from above)

Last Name	First Name	MI	Date of Birth	Last 4 digits SS#	
Street Address		City		State	Zip
Email	Home Phone	Work Phone		Cell Phone	
Employer	Employers Address	City		State/Zip	

Emergency Contact Information

Name	Home Phone	Relationship
Address	Cell	D.O.B.

Insurance/Policy Holder Information, Required: (Please present insurance cards to receptionist)

Primary Insurance	Effective Date		Policy Holder Name	Employer
Policy Holder Birthdate	Group #	ID Number	Relationship to Patient	SS #

Secondary Insurance

Secondary Insurance	Effective Date	Policy Holder Name	Employer
Policy Holder Birthdate	Policy Number	Relationship to Patient _Self _ Spouse _ Parent _ Child _Other	SS#

Advanced Directives

Do you have an advanced directive (living will) _____YES _____NO
If yes, at which hospital is it filed? _____

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How did you hear about our office?

___Advertisement _____Friends/Family _____ Physician _____ Other _____
Whom may we thank for your referral to our office? _____

PLEASE COMPLETE THE REVERSE SIDE

For Office Use Only: 1 _____ _____ 2 _____ _____ 3. _____ _____ 4. _____ _____

Privacy Policy

I acknowledge that I have received a copy of the privacy policies of Physicians and Surgeons for Women.

_____ _____
Patient Signature Date

AUTHORIZATION FOR TREATMENT

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of ultra sounds and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of PSFW, Inc. I realize that if a medical procedure or surgery is required, I will be given additional information.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

I consent to PSFW, Inc. using and disclosing my protected health information to carry out treatment, payment, or health care operations.
I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.
I understand that PSFW, Inc. reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager.
I have the right to revoke this consent by notifying PSFW, Inc. in writing, except to the extent that PSFW, Inc. has taken action in reliance on my consent.

MEDICARE PATIENTS ONLY-PLEASE COMPLETE THIS SECTION

1. Are you currently working? _____ Yes _____ No
   If yes, employer? _____
2. Do you have insurance through your employer _____Yes _____ No
3. Is your spouse currently working _____ Yes _____ No
4. Do you have insurance through your spouse's employer? ____ Yes ____ No
5. Is your visit related to an accident or injury? _____ Yes ____ No
   If yes, do you have any other insurance responsibilities for this bill? ____ Yes ____No

If you answered yes to any questions above, please provide insurance information to the staff.

I hereby authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid services and its agents any information needed to determine those benefits payable for related services. I hereby authorize Medicare/Medicaid to furnish to PSFW, Inc. any information regarding my Medicare claims under title XVII and XIX of the Social Security Act.

FINANCIAL AGREEMENT

I realize the bill is my responsibility. I assign and authorize payments be made directly to PSFW, Inc. of all insurance benefits and agree to pay any balance due.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient or representative's authority to act for the patient