Women's Telehealth Registration

PATIENT INFORMATION (Please Print)

Patient's Name: (First) _____ (MI) ____ (Last) _____ (Maiden) _____

Street Address: _____(No P.O. BOX)

City, State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail address: _____

Date of Birth: (MM/DD/YYYY) ____/____/_____ Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

Race: ☐ Asian ☐ Black/African American ☐ White ☐ Hispanic Other: _____ ☐ Declined

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Legally Separated ☐ Divorced

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Social Security Number: _____-_____-_____ Student Status: ☐ Full-Time ☐ Part-Time ☐ Not Student

Employer Name: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Not Employed ☐ Active Military

Emergency Contact Name: _____ Relationship: _____

Phone Number(s): _____ _____

Referring Provider Name: _____

PLEASE PROVIDE YOUR INSURANCE CARD(S) AND A PHOTO I.D. FOR THE OFFICE TO COPY*

PRIMARY INSURANCE INFORMATION *Check here if information is same as patient* ☐

Name of Insured: _____ Relationship to Patient: _____

Subscriber Date of Birth: MM____/ DD____/ YYYY_____

PLEASE PROVIDE SECONDARY INSURANCE INFORMATION IF YOU ARE COVERED UNDER ANOTHER PLAN

CONSENT TO TREATMENT

I hereby **consent to treatment** by Women's Telehealth and I understand that this treatment may be provided in whole or in part by Telemedicine.

Patient Signature: _____ Date_____

FINANCIAL POLICY

I have received a copy of the **Financial Policy** for **Women's Telehealth** and have read and understand that regardless of insurance; payment remains my personal responsibility (i.e. deductible, co-payment, co-insurance, and non-covered services). Any account sent to collections will be charged a 30% processing fee.

Patient Signature: _____ Date_____

MEDICAL RECORD AUTHORIZATION

I hereby authorize **Women's Telehealth** to furnish information to Insurance Carriers, and health care professionals as needed to coordinate my medical care.

Patient Signature: _____ Date_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby irrevocably assign to Women's Telehealth and Georgia Maternal Fetal Specialists all payments for medical services rendered to me by Women's Telehealth and Georgia Maternal Fetal Specialists.

Patient Signature: _____ Date_____

PERMISSION TO RELEASE/HIPAA

I hereby give my permission to Women's Telehealth to discuss my care-related communication with the following person(s):

Name: _____ Relationship to Patient: _____ Date of Birth: _____

Name: _____ Relationship to Patient: _____ Date of Birth: _____

Patient Signature: _____ Date_____

I have received a copy of the Notice of Privacy Practices and hereby give Women's Telehealth consent to use/disclose protected health information about me to carry out treatment, payment, and healthcare operations. I have the right to review and request a copy of the Notices of Privacy Practices at any time. I understand that I will receive care live or via Telemedicine.

Patient Signature: _____ Date_____

REV. 6.25.18