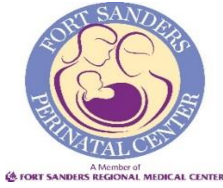

We Would Like to Thank You for Choosing

Fort Sanders Women's Specialists &
Fort Sanders Perinatal Center

for Your Health Care Needs.

PATIENT REGISTRATION

			Patient ID:
Last Name:	First Name:	MI:	Race/Ethnicity: American Indian or Alaskan Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White; Declined
Nickname:	Maiden Name:		
Date of Birth:	Social Security:		
Spouse Name:			Preferred Language:
Residential Address:		Preferred Phone: [ ]Home [ ]Cell	
		Home Phone:	
City:	State:	Zip:	Cell Phone:
Billing Address Different? Yes No	Employer:	Work Phone:	
Emergency Contact:	Relationship to Patient:	Phone Number:	
Emergency Contact *(not living with you)*:	Relationship to Patient:	Phone Number:	

INSURANCE INFORMATION

Primary Insurance:	Policyholder's Name:	
Relationship to Patient: *[ ]Self [ ]Spouse [ ]Child/Parent [ ]Other*	Policyholder's Social Security No:	
Member ID#:	Group #	Policyholder's Date of Birth:

Secondary Insurance:	Policyholder's Name:	
Relationship to Patient: *[ ]Self [ ]Spouse [ ]Child/Parent [ ]Other*	Policyholder's Social Security No:	
Member ID#:	Group #	Policyholder's Date of Birth:

I hearby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for services as described, realizing I am responsible to pay non-covered services. I understand that if my account is turned over to a collection agency, I will be responsible for any applicable fees. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Patient Signature: ______________________ Date: __________

Revised 9/4/2019

FORT SANDERS PERINATAL CENTER & WOMEN'S SPECIALISTS
DISCLOSURE CONSENT

I can ask for and receive a copy of the Notice of Privacy Practices for this office upon request.

We are committed to providing an office environment that is professional, caring, and respectful of your time and privacy. The following agreement outlines communication information and office policies that are important in providing you with the best care.

I understand that it may/will be necessary to contact me with test results, billing questions, information about referrals to other offices, or to obtain medical information which may be needed to provide appropriate care.

What telephone_number do you want us to call? ______________________

May we leave messages on *your* voice mail or answering machine?

YES ☐ NO ☐ N/A ☐

Is there anyone other than yourself we can speak to or leave messages with?

YES ☐ NO ☐ **If *YES* :**

Name: ______________________ **Relation:** ______________ **Phone:** __________

Name: ______________________ **Relation:** ______________ **Phone:** __________

Electronic (EMAIL) Communication: ______________ @ ______________

EMAIL : YES ☐ NO ☐ PORTAL: YES ☐ OPT OUT ☐

I understand FSWS & FSPNC may need to disclose my protected healthcare and personal information to another entity (referring doctors, primary-care doctors, pharmacies, making referrals, your insurance company) and I consent to disclosure for these permitted uses, by fax or telephone.

Referring Doctor: ______________________________ **Phone:** __________

Primary Care Doctor: ______________________________ **Phone:** __________

PATIENT & GUEST AGREEMENT

NO FOOD OR DRINKS are to be brought into our waiting rooms or exam rooms. Please eat or drink all food items before entering our suite.

Due to **LIMITED SPACE** in our office we can only allow **2 people**, including children, back with you during your appointment. If you are having an ultrasound, we allow 2 people to switch out half way through the ultrasound so other family members may be included.

CELL PHONES: Please TURN OFF/SILENCE all cell phones while in our office. NO PHOTOGRAPHS are to be taken out of respect for the privacy of other patients.

I have read the agreements above and understand. I can ask for and receive a copy of this notice for my records.

____

Patient Signature Date

Signature of Guardian if Patient is a Minor Date Patient ID

Revised 9/4/2019

PATIENT REGISTRATION CONTINUED
FINANCIAL AGREEMENT

We are happy that you have chosen us to provide your medical care. Our primary goal is to furnish your medical needs in a caring and competent manner. We do realize that medical care is expensive. Fortunately, most patients do have medical insurance to assist them in paying bills that accrue at our office. We will, as a courtesy, file the patient's visit with the insurance company as long as the patient has provided us with proper insurance information.

1) For GYN visits and office procedures, our office expects payment at the time services are rendered. The patient's copay is due at check in, before services are rendered.

2) For all maternity / obstetrical services, our office expects payment at the time services are rendered. We will file patient visits with the insurance company. NOTE: If the insurance company has a percentage based amount for the patient to pay, our office will assist in setting up payment arrangements for the amount due to be paid by the patient in advance of the estimated delivery date.

3) SURGERY FEES: Our office will provide the patient with an estimate of the physician fee. We will determine the amount not covered by the insurance company. This amount is what the patient will be held responsible for. Our office does require that the patient prepay in advance for any surgical procedures, all copayments, deductibles, co-insurance, or any other amount not covered by your insurance at least seven (7) days prior to your surgery date. After the surgery has been performed, our office will file the insurance claim for the patient.

4) All insurances that require a referral must have the referral completed before receiving treatment of any kind. Failure to obtain the referral prior to treatment may result in the patient being held responsible for the full amount owed for any medical treatment.

5) Finances are rarely discussed with the physician or other clinician. Any questions regarding finances or about the patient's account balance should be directed to a member of our office staff.
   Our billing office can be reached at **(865) 331-1982.**

6) **Any outstanding account balance with our office will require a payment upon every visit to our office. Any outstanding account balance over 90 days may be turned over to a collection agency unless the patient or Legal Guardian has spoken with a member of our billing department and made financial arrangements. Some obstetrical appointments may be rescheduled until such time as account balances are paid**.

7) In the event of a returned check for **insufficient funds**, or any other reason for denial, your account will be charged with a $25 account handling fee.

Patient Signature: ______________________ Date: ____________

Signature of Guardian ______________________ Date: ____________

If Patient is a minor please fill out the following:

____

Parent or Legal Guardian Name Address Phone Number

Patient ID: ______________

Revised 9/4/2019