The Women's Group

New Patient Registration

Last Name_____ First Name _____

Middle Name _____ Previous Name _____

Cell Phone _____ Home Phone _____

Address _____

City, State _____ Zip Code _____

Email Address _____

Date of Birth _____ Age _____ Gender _____

Language spoken _____
Race: __ African American/ Black __ American Indian __ Asian __ Caucasian/ White __ Unknown __ Decline
Ethnicity: __ Hispanic Origin __ Not Hispanic or Latino __ Unknown __ Decline

Marital Status: __ Single __ Married __ Partner __ Separated __ Divorced __ Widowed __ Decline

Employer _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

Insurance Information

Insured Person's Last Name _____ First Name _____
Relationship to Patient _____

Member ID number _____ Group # _____

Address (if different) _____
City, State _____Zip Code _____

Cell Phone _____ Home Phone _____

Email Address _____

Date of Birth _____ Gender __ Male __ Female

The Women's Group

Consent to Treatment

Knowing that I have presented for medical treatment, I hereby voluntarily consent to such medical treatment including, but not limited to medications, medical procedures, diagnostic procedures, lab tests, and medical treatment by a physician, his/her assistants or his/her consignees as may be necessary in her judgement. I understand that testing for infectious conditions such as Human Immunodeficiency Virus (HIV) may be included. I understand that no guarantees have been made as to the result of treatments or examinations.

Patient/Guardian Signature _____
Print Name _____
Relationship to Patient _____ Date _____

Authorization for Electronic Healthcare Communication

I authorize The Women's Group to contact me for the purpose of healthcare related messages and their billing services to contact me via the following technologies:

Text __ Agree __ Decline
Email __ Agree __ Decline
Phone __ Agree __ Decline
This consent is valid until revoked.

Assignment of Benefits

In consideration of services rendered, I hereby irrevocably assign and transfer to The Women's Group for myself and my dependents all rights, title, and interest in the benefits payable for services rendered at this facility or by any third party practitioners provided in any insurance policy(ies) under which I or any of my dependents are insured. Said irrevocable assignment and transfer shall be for the purpose of granting The Women's Group and third party practitioners an independent right of recovery in any policy(ies) of insurance, to which benefits may be payable for an outpatient treatmen or professional services, but shall not be construed to be obligation of this facility or any third party practitioners to pursue any such rights or recovery.

I hereby authorize and direct all insurance companies under which I am insured to pay directly to The Women's Group or any third-party practitioners, all benefits due under said policy(ies) by reason of services rendered therein. I will pay The Women's Group and third party practitioners for all charges incurred, or alternatively, for all charges in excess of the sums actually paid by said policy(ies).

Patient/ Guardian Signature _____
Print Name_____
Relationship to Patient _____ Date _____

The Women's Group

Medication History Consent

Up-to-date medication history is very important in helping us provide quality medical care and avoid potentially dangerous drug interactions.

A medication history is a list of prescription medications that doctors or other providers have prescribed for you. This list is collected from several sources including your pharmacy and/or insurance company and my include medications to treat mental health conditions or communicable diseases such as Human Immunodeficiency Virus (HIV) or Hepatitis B.

By signing this consent form, you give The Women's Group permission to use e-prescribing tools to obtain your medication history. You may cancel or revoke this consent at any time. However, any medication information already added to your medical record due to this consent will remain part of your record.

Accepted: _____ (initial)

Printed Name _____ Date of Birth _____

Signature _____ Date _____

Relationship to Patient _____

Request to Withdraw Consent

Printed Name _____ Date of Birth _____

Signature _____ Date _____

Relationship to Patient _____