NORTHSIDE WOMEN'S AND MATERNAL-FETAL SPECIALISTS
PATIENT REGISTRATION FORM
PATIENT INFORMATION

PT. NAME:	**SS#:**	**DOB:**
MARITAL STATUS: S M S D W	**HOME PHONE #:**	
STREET ADDRESS (No PO Box):		
CITY:	**STATE:**	**ZIP:**
Occupation (**Indicate if Student**):	Employer:	
Employer's Address:	Work Phone#:	
Spouse's Name:	Sp. SS #:	Sp. DOB:
Spouse's Employer:	Spouse's Occupation:	
Sp. Employer's Address:		Work Phone #:
Emergency Contact Name/#:		Referred to us By:

PLEASE PROVIDE THE RECEPTIONIST WITH YOUR INSURANCE CARDS AND DRIVERS LICENSE SO WE CAN MAKE A COPY. THANK YOU.

NOTE: Do you speak English? : ___ Very Well ___ Well ___ Not Well ___Not at all

FINANCIAL POLICY STATEMENTS/AUTHORIZATIONS

A) FINANCIAL POLICY

We make every effort to keep down the costs of medical care. Our fees are comparable to those of other specialists in our area with equivalent training , experience, and credentials.

1) **Insurance Filing:** We participate in a number of insurance plans and will work with you and your insurance carrier. However, you must make sure that your plan obligations are met. These obligations include: providing us with a current insurance card on every visit, paying the patient portion due at the time of your visit, using network providers for referrals (if necessary), and participating in precertification processes. Your insurance plan requires us to work together. **No insurance covers 100%.** There are always limitations, non-covered services and exclusions. Even with 2 or more insurances, there may be services for which you are responsible. If you have questions regarding your coverage, they should be directed to your insurance carrier.

2) **Patient Portion Due:** Regardless of insurance, payment remains your personal responsibility. Your designated patient portion due may include: deductibles, co-pays, co-insurance, and non-covered service charges. **Our policy is to collect all patient portions due at the time of service.** It is our practice policy that if the pt's outstanding balance exceeds $150, they will be asked to see a Reimbursement Specialist prior to services being rendered. We do not wish to cause an embarrassment for any patient. Please let us know immediately if you have a financial issue or question about our services. **We accept cash, check, and all major credit cards for your convenience.**

I have read and understand the above financial policy. PATIENT SIGNATURE: ________________________________

B) MEDICAL RECORD AUTHORIZATION: It is imperative that to care for you we have access to your records. Other entities may also require information contained in your medical record to care for you or pay for services.
AUTHORIZATION: I hereby authorize NORTHSIDE WOMEN'S SPECIALISTS AND MATERNAL-FETAL SPECIALISTS to furnish information to insurance carriers, and health care professionals as needed to coordinate my medical care.

PATIENT SIGNATURE:____ DATE: _______________

C) ASSIGNMENT OF INSURANCE BENEFITS: "Assignment" simply means that the patient agrees that the insurance company 's payment for services rendered be made directly to the physician . This is not payment in full.
ASSIGNMENT: I hereby irrevocably assign to Northside Women's Specialists and Maternal-Fetal Specialists all payments for medical services rendered to me by Northside Women's Specialists and Maternal-Fetal Specialists.

PATIENT SIGNATURE: ____ DATE: ____________

WE GREATLY APPRECIATE YOUR COOPERATION IN COMPLETING THIS REGISTRATION PROCESS !