Women's Healthcare of Eastern Carolina

REGISTRATION

(Please print)

Date _____ Home Phone ( ) _____ Cell Phone ( ) _____

PATIENT INFORMATION

Name_____ SS/HIC/Patient ID #_____
Last Name First Name Middle Initial

Address _____ Age _____ Birthdate _____
City_____ State _____ Zip _____ E-mail _____
Gender ____F _____M Language _____ Single _____ Married_____ Minor _____
Race _____ Ethnicity _____ Separated ____ Divorced ____ Widowed _____
Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone ( ) _____
Whom may we thank for referring you? _____ Emergency Phone ( ) _____
In case of an Emergency, who should be notified? _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____Birthdate_____ _ Soc. Sec. # _____
Address (If different from patient's)_____ _____ Phone ( ) _____
City _____ Sate _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone ( ) _____
Insurance Company _____
Contact #_____ Group # _____ Subscriber #_____
Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? _____ Yes _____No
Subscriber Name _____ Birthdate _____ Relation to Patient _____
Address (If different from patient's) _____ Phone ( ) _____
City _____ _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone ( ) _____
Insurance Company _____ Soc. Sec. # _____
Contact # _____ Group #_____ Subscriber # _____
Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent (s), have insurance coverage with _____ and assign directly to Women's Healthcare of Eastern Carolina all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient/Parent/Guardian/Legal Representative Date

_____ _____
Please print name of Patient/Parent/Guardian/Legal Representative Relationship to Patient

Telephone: 252-477-1001 Fax: 252-362-3703
103 Airport Road, Kinston, North Carolina 28501

Women's Healthcare
OF EASTERN CAROLINA

Authorization For Release of Protected Health Information

Please Mail Records Over 25 Pages to Our Office

I authorize:
Name _____ Phone (_____) _____
Fax Number of Facility Requesting From_____
Address _____City_____State _____Zip_____

to disclose a copy of health information to Women's Healthcare of Eastern Carolina on the following patient:
Patient Name _____ Phone (_____) _____
Soc. Sec.# _____ Birthdate _____
Address _____City_____State_____Zip_____
Race _____ Ethnicity_____
Language _____ Gender ☐ F ☐ M _____

The information to be disclosed shall be:
___ All Records
___ Labs
___ Mammogram
___ Pap Smear
___ Pathology
___ Physical Exams/Office Visits
___ Prenatal
___ Surgery
___ Other (specify) _____

I understand the information will include records relating to:

- Alcohol and/or Drug Dependency
- HIV Antibody Test and Diagnosis/Treatment
- Mental Health Treatment

This Disclosure is being made for the following purpose:
___ Continuing Care
___ Insurance
___ Moving
___ Transfer Care

I understand that the information released cannot be re-disclosed. I also understand that the facility, its employees, officers, and physicians are hereby released from any legal responsibility of liability for disclosure of the above information to the extent indicated and authorized herein. This release will expire 30 days from the date of signature.

_____
Signature of Patient/Guardian/Legal Representative Date

_____
Witness Date

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Women's Healthcare
OF EASTERN CAROLINA

Payment Policies

The undersigned hereby agrees to reimburse Women's Healthcare of Eastern Carolina directly for any and all services and supplies provided to the patient.

If the patient's insurance company has not paid within 90 days of billing, the patient is responsible for the balance in full. Balances owed after insurance payment are due in full within 30 days, unless other arrangements have been made through our Insurance/Billing Department.

Please Note: Insurance is filed as a courtesy for our patient's benefit. The Patient/guarantor is still responsible for all charges and payments. Any benefits quoted are estimates and should not be taken as a guarantee of insurance payment. Patients are responsible for their co-insurance at the time of their visit.

Patients without insurance are expected to pay in full at the time of service. Payment is required unless arrangements have been made with the Insurance/Billing Department. The patient/guarantor understands that all amounts quoted are estimates and additional charges may incur during treatment or testing.

Unless otherwise instructed, we send all pap smears and biopsies to Lab Corp. **The patient will receive a separate bill from these facilities.**

All insured patients must present their current eligibility cards and pay all co-pays and co-insurance fees at the time of their visit.

Office Fees:

- Office Visit/Nurse Visit: Co-pay fee determined by patient's insurance
- Duplicate/Lost Prescription: $25
- Forms/FMLA/Medical Records: $15
- Non-emergent after-hours calls: $25
- No Show/Same day cancellation: $50

*We understand that an emergency may necessitate a late (or same day) cancellation.
In the event this occurs, the patient may not be charged a fee.

The undersigned has read and received a copy of the form and certifies that they are the patient, the patient's legal representative, or are duly authorized by the patient as the patient's general agent to execute this consent to pay for services and accepts its terms.

_____
Signature of Patient/Guardian/Legal Representative

_____
Date

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