REGISTRATION

(PLEASE PRINT)

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

PATIENT INFORMATION

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

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

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 _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ 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. # _____

Contract # _____ 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
Name of Insurance Company(ies)
Dr. _____ 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 authorize 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 or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Office Policy

We want our patients to have a positive experience in our office. Therefore our goal is to create a comfortable and relaxing atmosphere for everyone. We want to keep order and be able to attend to your needs in an orderly manner. With this being said we have established the following policies:

1. **Eating or drinking** in the waiting area and beyond the waiting area is prohibited. This Includes the rooms.

2. **Talking** on the **cell phone** is prohibited in the waiting area and beyond the waiting area. This includes the rooms. Please keep your cell phone on vibrate or on silent.

3. **Children** are always welcome **if** they are under **adult supervision at all times.**

4. **$50 will be applied to your account for regular missed appointments if we are not notified 24hrs in advance. For annual exams there will be a cancellation fee of $185.00 if we are not notified 48 hours in advance.** Please note that there is an answering service after office hours, therefore no excuse will be accepted.

5. For any lost or **misplaced prescriptions** there will be a **$10** charge.

6. For patients with out insurance and with insurance, are expected to pay at the time services are rendered. This includes co-pays, co-insurances and deductibles. If a payment is not made at the time, there will be a **$10** charge. We **DO NOT** accept personal checks at the time services are rendered.

7. There is a **$25** charge for medical records and a **$15** charge for any medical documentation that needs to be filled out by the doctor. Payment is expected at the time they are picked up. **Please allow 5 business days.**

8. **Should there be any services your insurance denies, you will be responsible for the balance.**

By signing you are agreeing to the terms of the office policies.

Print Patient Name _____ Patients Signature _____ Date _____

SPANISH WOMEN'S CARE, LLC
307 Maple Ave, West ·Suite J. · Vienna, VA 22180
703-281-7620 - 703-255-6810 (fax)

Authorization to Release Patient Information

I_____, herby authorize the doctor and staff of this office, to release any and all information pertaining to my health care, test results, procedures, billing and/ or accounting information to the following person(s) or agencies.

- o Spouse _____
- o Parents _____
- o Other_____

I further authorize the doctors and their staff to dispense results off my medical exams in one or more of the following ways; please check:

We may leave a message during business hours to return call to physician's office.

- o On answering machine at home
- o Voice mail at work
- o Cell phone
- o E-mail _____

We may leave type of test and test results:

- o On answering machine at home
- o Voice mail at work
- o Cell phone
- o E-mail _____

I understand that this office will release any information to those persons whom I have determined may receive this information without separate consent. In addition, I understand that this relates to all medical as well as billing information. This will be actively enforced. If you wish to change the status of this form, you must do so in writing.

_____ _____
Patient Signature Date

I have been given a copy of the office privacy notice to read.

_____ _____
Patient Signature Date