Patient Registration

OFFICE USE ONLY

	New Patient
	Current Patient UPDATE
	OB/GYN (circle)

Please Complete All

Date	Acct No.					
Patient Name Last First Initial				Marital Status ☐S ☐M ☐D ☐W	Sex ☐M ☐F	
Home Address	City State Zip			Home Telephone		
Employer/School	Employer/School Address			Work Telephone		
Occupation	Social Security Number	Driver's License No. State	Birth Date	Age	Living Will? ☐Yes ☐No	
Spouse or Parent Name	Employer's Address			Work Telephone		
Name of Financially Responsible Person (if Different from Patient) ☐Spouse ☐Parent ☐Other						
Address (if Different from Patient)			Home Telephone	Work Telephone		
Primary Health Insurance Co. Name	Policy Holder		Policy Holder's Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other			
Insurance Co. Address	ID/Policy No.	Group No.	Coverage Code	Effective Date / /		
Secondary Health Insurance Co. Name	Policy Holder		Policy Holder's Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other			
Insurance Co. Address	ID/Policy No.	Group No.	Coverage Code	Effective Date / /		
Family Physician	Referred By	Address	Reference No.	Telephone		
Any Member of Family Treated by Our Group Before ☐Yes ☐No	Emergency Contact		Telephone			
Your Current Problem: Work Related? ☐Yes ☐No Accident Case? ☐Yes ☐No Automobile Involved? ☐Yes ☐No						
Have You Missed Time From Work? ☐No ☐Yes (specify dates)	If Due to Work-Related Injury, Fill out the Section Below.					
Date of Injury / /	Was Injury Reported to Supervisor? ☐Yes ☐No	Name of Supervisor				
Employer at Time of Injury	Address	Telephone				
Description of Injury:						
Workers' Compensation Insurance Carrier	Claim Number					
Workers' Compensation Insurance Carrier Address	Telephone					
Is Attorney Assisting You With This Worker's Comp Claim? ☐Yes ☐No						
Attorney's Name	Address	Telephone				

Email Address_____

Patient Name_____

MESSAGE AUTHORIZATION

WARNER WELLNESS INSTITUTE

_____

(Name of Provider/Clinic)

considers patient confidentiality to be of utmost importance and concern. In an effort to ensure that your privacy is protected, please read and sign the following consent form.

AUTHORIZATION

I authorize the provider/clinic to leave on my **home** answering machine, telephone number_____ or information left on my **work** voicemail, telephone number_____; pertaining to the following (check all that apply):

____ Date and time of upcoming appointment

____ Laboratory results (e.g., blood test, Pap smear, urine or other cultures)

____ X-ray, CT scan, MRI or other radiological results

____ Reminder to schedule recurring screening services or testing (e.g., Pap, annual)

____ Email Address_____ for information related to our office including upcoming office promotions.

I understand that this authorization will remain in effect until such time that I submit, in writing, revocation of my authorization. I understand that by giving my consent, information about my personal health care could be made available to members of my family and/or others in my home who have access to my telephone messaging system.

Signed: _____ **Date:** _____

NO AUTHORIZATION

_____I **do not** authorize any messages related to my health care to be left on my **home** answering machine.

_____I **do not** authorize any messages related to my health care to be left on my **work** voicemail/answering machine.

Signed: _____ **Date:** _____

AUTHORIZATION REVOKED

Message authorization revoked on_____

Initials of individual receiving written revocation: _____

WARNER WELLNESS INSTITUTE
Prescription Refill Request

Patient Instructions:

In order to obtain a refill for your prescriptions, please complete this form and fax it to (202) 723-1992. This form cannot be used to request a new or change of a medication.

Patient's Name: _____

Date of Birth: _____

Physician's Name: _____

Phone Numbers: Home: _____work: _____cell: _____

Address: Street: _____

City: _____State: _____Zip: _____

Name of Medication and Dosage: _____

Frequency Used: _____

Please select one of the following:

_____Mail prescription to my home address to use at a local pharmacy.

_____Mail prescription to my home address to use with a mail order pharmacy.

_____Call in the prescription to my pharmacy:

Pharmacy Name: _____

Pharmacy Phone#: _____

Office Use Only:

_____Prescription mailed on: _____/_____/_____

_____Prescription called into pharmacy on ____/_____/____Spoke with: _____

_____Prescription not refilled because: _____

Authorized Signature: _____Print Name: _____

WARNER WELLNESS INSTITUTE

Statement of Patient Financial Responsibility

Patient Name: _____ **DOB:** _____

WARNER WELLNESS INSTITUTE appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full for our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to WARNER WELLNESS INSTITUTE, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Green Pregnancy and Center for Women's Health, the full entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature_____ Date_____

Guarantor Signature_____ Date_____

(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature_____Date_____

Consent for Treatment and Authorization to Release Information

I hereby authorize WARNER WELLNESS INSTITUTE, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment.

I further authorize WARNER WELLNESS INSTITUTE, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature_____Date_____

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours (one business day) prior to cancelling your appointment or rescheduling your appointment or you will be charged a $50.00 fee.

I have read and understand the above information, and I agree to the terms described.

Patient/Guarantor Signature_____Date_____

Form Completion and Replacement for Lost Items

Should you require forms for employment, school, disability, or any other purpose; you must assume the cost of preparing these forms. There must be a signed authorization form from the patient accompanying these forms. Forms request must be provided at least one week before the due date. The charge for form completion is $25.00 per form.

The practice provides prescriptions that are medically necessary and appropriate in your treatment, referrals for radiology, and requisitions for laboratory testing. If any of these items are lost and a replacement is necessary; there is a $25.00 fee that must be paid before the replacement is provided.

Patient/Guarantor Signature_____Date_____

.Self-Pay

I do not have health insurance and will be responsible for services rendered here at WARNER WELLNESS INSTITUTE. I agree to pay WARNER WELLNESS INSTITUTE, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature_____Date_____