First State Women's Care
Patient Registration Form

Preferred Provider (circle):
Dr. Lindsey Davis Dr. Gregory DeMeo Dr. Alexander Kirifides
Dr. Stefanie Marshall Dr. Gordon Ostrum, Jr.
Stefanie Barnes, CNM Sharon Buck, CNM
Melissa Meredith, CNM Michelle Pietlock, NP

Date:_____

Last Name: **First Name:** **Middle Name:**

Date of Birth: **SSN:** **Maiden Name:**

Street Address: (Include Apartment #, if applicable) **City:** **State:** **Zip-code:**

Home Phone: **Work phone:** **Cell phone:** **Primary Phone: (circle one)**
Home – Work - Cell

Email Address: **Preferred Method of Communication: (circle one)**
Mail - Home phone – Cell phone – Work phone

Race: (circle one)
American Indian/Alaska Native
Asian
Black/African American
Native Hawaiian/Pacific Islander
White
Other Race
Decline to Answer

Ethnicity: (circle one)
Hispanic or Latino
Not Hispanic or Latino
Decline to Answer

Primary Language:
English
Spanish
Other:_____

Marital Status: (circle one)
Divorced
Domestic Partner
Married
Separated
Single
Widowed

Preferred Local Pharmacy: (Include pharmacy location)

Preferred Mail Order Pharmacy: (Include address/city/state if available)

Employer Name: **Occupation:**

Family Physician: **Family Physician Phone#:**

EMERGENCY CONTACT:

Contact Name:	Address:	Phone:	Relationship to patient:

If the patient is NOT the primary/secondary insurance holder, please provide the following information:

Primary/Secondary Insured's Name:	Relationship to patient: (circle one) Spouse – Parent/Step-parent – Legal Guardian
Date of Birth: MM/DD/YYYY	SSN:
Home Address:	
Employer:	Employer's address:

INSURANCE:

PRIMARY Insurance Company Name: Policy/Member ID #: Group#:	Coverage Under: (Circle One) Patient/Self - Spouse – Parent/Step-parent – Legal Guardian
SECONDARY Insurance Company Name: (If applicable) Policy/Member ID #: Group#:	Coverage Under: (Circle One) Patient/Self - Spouse – Parent/Step-parent – Legal Guardian

HIPAA Acknowledgement

I hereby acknowledge that I have received or had the opportunity to review a copy of Women First, LLC's *Notice of Privacy Practices*, and I further authorize Women First, LLC to release medical information to my insurance carrier, physician's office, any treating facility, or Power of Attorney. I also acknowledge that past medication history will be obtained from my pharmacy benefit manager in order to assist my providers with my care.

I give my permission to release information regarding appointment dates/times and my protected health information, including but not limited to, insurance, address, phone number, test results, health care information, and treatment to the following:

	Name of Person	Relationship to Patient
1.		
2.		

_____ _____ _____

Printed Name Patient Signature Date

Financial Policy

Thank you for choosing Women First, LLC. We are dedicated to providing our patients with the best possible care and services. We would like to take the time to review some of our office policies.

1. We accept cash, check, Visa, or MasterCard. Returned checks are subject to a $30 service charge.
2. All payments are due at the time of service unless previous arrangements have been made.
3. If an account is delinquent and placed with our outside collection agency, you will be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.
4. Medicare usually only covers routine exams and pap smears every two years. You are responsible for any deductibles or coinsurance not covered by Medicare.
5. We require 24 hour notice of cancellations of your appointment. If proper notice is not given, you may be subject to a $25 missed appointment fee.
6. We require at least 7 days' notice if you need to reschedule or cancel your outpatient or inpatient surgical procedure. If notice is not given, you will be subject to a $50 fee.
7. We will be happy to complete FMLA/Disability forms. This is subject to a $20 administrative fee. Please allow 7-10 business days for completion of any forms.
8. Copies of Medical Records will be subject to a fee schedule as defined by Delaware Law. Please allow 7-10 business days for completion of your request.
9. Please verify with your insurance company which lab and radiology facilities you may utilize. Each insurance company has different preferred providers.
10. It is the patient's responsibility to check with the insurance company to determine if authorization or referrals are needed. If you need our office to process an authorization/referral for services, we require 48 hours' notice to complete the request.

I have read and fully understand the office and financial policies set forth. I agree to the terms of the above policies. I also understand and agree that the terms of the financial policy may be amended by the practice at any time without prior notification to the patient.

_____ _____

Patient Signature Date

I authorize release of any information necessary to process claims on my behalf.
I authorize payment of medical benefits to the physician or supplier for services rendered.
I authorize release of pertinent medical information to Christiana Care Health Services, and in the event of an abnormal Pap smear or abnormal mammogram, to the facility performing the study.

_____ _____

Patient Signature Date