ADVANCED WOMEN'S HEALTH OF NASHVILLE
OBSTETRICS · GYNECOLOGY · INFERTILITY

REGISTRATION FORM

Patient's
Last Name: Maiden: First: MI:

Address: Zip:

Home phone: Cell phone: Work phone:

Reminders: I prefer ○ Text message or ○ Voice message to ○ home, ○ cell, or ○ work
Preferred Time: ○ Morning ○ AfterNoon ○ Evening Preferred Language: _____

Messages: We may leave the following on your voice message? ○ Account balance ○ Health reminders ○ Lab and pathology results
May we send your lab and pathology results by mail? ○ Yes ○ No
Is there another number where we may leave messages re: appointments, account information, lab and pathology results?
Phone #: _____

MEDICAL INFORMATION DISCLOSURE

May we disclose your appointment information or medical information to members of your family? ***circle one:***

Name: _____ Relationship: _____Phone#_____; Medical *info only Appointment info only*

To enhance your care, we access your prescription history and pharmacy benefit files that are available electronically based on pharmacy, state, and insurance data. Please indicate here if you wish to deny this access. ○ I elect to OPT-OUT

ADDITIONAL INFORMATION

Pharmacy Name: Phone: Address:

Birth date:	Age:	Gender:	Marital status:
Social Security #:	Employer:	Occupation:	Spouse name & DOB:
Email:	Race:	Ethnicity: ○ Not Hispanic ○ Hispanic ○ Latin	

Primary Care Physician: Phone: Referred by:

EMERGENCY CONTACT - Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Work phone:

INSURANCE INFORMATION *(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)*

Please indicate **primary insurance** name:

Subscriber's name:	Subscriber's S.S. #:	Employer:	Birth date:	Relationship to patient:

Name of **secondary insurance** name (if applicable):

Subscriber's name:	Subscriber's S.S. #:	Employer:	Birth date:	Relationship to patient:

AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFIT, & FINANCIAL POLICY

I authorize Advanced Women's Health of Nashville (AWH) to provide medical treatment. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to AWH for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. I understand that payment for today's visit and future visits are due at the time of treatment. I understand that AWH is part of a single multi-specialty physician group Advanced Health and that any physicians I see in this network may have access to some of my medical history. We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing. If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we must refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we must refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient/Guardian signature **Date**