Thank you for choosing Women Physicians Associates OB/GYN as your health care provider. Our medical staff is dedicated to helping you maintain good health by providing you with quality OB/GYN care during your pregnancy, well checkups, or for any gynecological problems you may be experiencing.

We look forward to your visit and the opportunity to discuss any health concerns you may have. Our office is located in the Palmetto Richland Memorial Medical Complex. We are located in 9 Richland Medical Park on the sixth floor in Suite 620. Parking is available at the street level in the front of the building and in the parking garage directly behind the building. *(Map available at www.wpaobgyn.com)*

A Patient Information Sheet, Financial Agreement Sheet and an EMR history login letter are enclosed. ***If you have been under the care of another physician please make arrangements to have pertinent records sent to our office***. Please complete and bring with you to your appointment the Patient Information Sheet and Financial Agreement Sheet.

Please complete your online Medical history BEFORE your scheduled appointment. Failure to complete the online history could result in having your appointment rescheduled. If you do not have internet access you should plan to arrive 45 minutes before your schedule appointment and use our computer. Our staff is here to answer any questions you may have regarding your appointment and data collection process. We are excited about being on the front end of such technological advances.

As a courtesy, our office will try to notify you of any schedule changes that may affect your appointment. We ask that you please do the same. If you must miss your scheduled appointment, please contact our office by calling 779-6776 option 3 as soon as possible. This will give us an opportunity to reschedule your visit and possibly provide an opportunity for another patient who may need to be seen.

Our patients are special to us and we look forward to meeting you and participating in your health care needs.

Sincerely,

Lilly S. Filler, M.D.
Sharon I. Eden, M.D.
Jennifer M. Risinger, M.D.
Lauren J. Painter, M.D.
Kimberlee T. Goode, M.D.
Jennifer B. Linfert, M.D.
Janice L. Coleman, M.D.

WOMEN PHYSICIANS ASSOCIATES OB/GYN, P.A.

REGISTRATION FORM

(Please Print)

Today's date: / /

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mrs. ❑ Ms. ❑ Miss	Marital status (check one) ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name? (Former name):	Birth date: / /	Age:	Social Security no.:

Street address: ❑ Permanent ❑ Temporary	Cell phone no.: ( )	Home phone no.: ( )

City:	State:	ZIP Code:	E-mail address:

Occupation:	Employer (school if student):	Employer phone no.: ( )

Spouse or parent's name (indicate which)	Street address (if different):

Social Security no.:	Employer:	Occupation:	Employer phone no.: ( )

Other family members seen here:	Who referred you to us? :

INSURANCE INFORMATION

(Please give your insurance card to the Care Coordinator at check-in)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Nearest relative not living with you:	Address:	Home phone no.: ( )

Primary insurance company:	Address of insurance company:	Phone no. of insurance company: ( )

Effective Date: / /	Policy ID or SSN:	Group no.:	Name of policy holder:	Relationship to policy holder:	Policy holder DOB: / /

Pre-certification required? ❑ Yes ❑ No ❑ Unknown	Pre-certification phone no.: ( )	What lab does your insurance company require you to use? (if known)

Secondary insurance company:	Address of insurance company:	Phone no. of insurance company: ( )

Effective Date: / /	Policy ID or SSN:	Group no.:	Name of policy holder:	Relationship to policy holder:	Policy holder DOB: / /

Pre-certification required? ❑ Yes ❑ No ❑ Unknown	Pre-certification phone no.: ( )	What lab does your insurance company require you to use? (if known)

INSURANCE AUTHORIZATION AND ASSIGNMENT

(PLEASE READ & SIGN)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I authorize the release of any and all medical information necessary and required by my insurance company. This release will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as the original. **ASSIGNMENT OF BENEFITS:** I hereby assign, transfer, and set over to Women Physicians Associates, OB/GYN, P.A. all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with my insurance company. This assignment will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as an original.

Patient/Guardian signature	*Date:*

Thank you for choosing Women Physicians Associates as your Ob/Gyn healthcare provider. Our staff is dedicated to helping you maintain good health by providing you with quality Ob/Gyn care during your pregnancy, well check-ups or for any gynecological problems you may be experiencing.

With regard to insurance:

- An insurance policy is a contract between you, your employer (if your insurance is an employment benefit) and the insurance company. We are not a party to that contract.
- Insurance contracts are not all the same. Their benefits vary with regard to the medical services they will pay for and the percentage of the medical costs they will reimburse you for. All office charges are ultimately your responsibility.
- Our insurance specialists will pre-certify all surgical procedures with your insurance company and explain insurance contract benefits to all obstetrical patients. We require that all surgical and obstetrical patients pay a deposit; our insurance specialist will get that information to you in advance.
- At times it may be necessary for our insurance department to complete disability forms for you. There is a $15.00 per form processing fee. These forms take 5-7 working days to complete.
- If you have an outstanding balance and your insurance company does not pay our office in full within 30 days of the incurred cost, we will ask you to contact your insurer to expedite payment. If your insurance company does not pay in full within 45 days, you will be required to pay your outstanding balance.
- There is a $30.00 return check fee; this will be a direct bank draft.
- Account balances over 90 day are sent to outside collections, unless you contact our office and arrange a Payment plan. We understand that temporary financial problems occasionally affect timely payment of patient accounts. If a problem ever exists, please contact one of our account specialists so they can help you manage your account. (Appointments will not be scheduled if your account is over 120 days past due and monthly payments are not current.)

Again, thank you for choosing Women Physicians Associates as your OB/GYN health care provider. We appreciate the trust you are placing in us and welcome the opportunity to serve you.

Patient's Signature: ____ Date: ______________________

Acknowledgment of Receipt of Privacy Practices

I hereby acknowledge that I have been given an opportunity to review the privacy practice at Women's Physicians Associates. I understand that I may obtain a copy of the Notice of Privacy at my request.
This notice has been issued and considered effective on the date signed. We will keep this signed form on file for a minimum of six (6) years.

List all individuals who may receive medical information from our facility

____

____

____

I understand that any person who is not a legal guardian whose name does not appear on the above list will not be given access to any medical information without written permission

____
Patient's full name (print)

____ ______________
Signature of patient's or legal representative Date

____ ______________
Signature of staff receiving acknowledgement Date

Nine Richland Medical Park, Suite 620 | Columbia, SC 29203 | 803.779.6776