Sarah B.Kline, MD Women's Health Care LLC

REGISTRATION FORM

(Please Print) **Today's Date: / /**

Patient's last name:		**First:**	**Middle:**
Birth date: / /	**Age:**	**Marital status (circle one)**	**Single / Mar / Div / Sep / Wid**
Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**		
Street address:	**P. O. Box:**	**Email Address:**	
City:	**State:**	**ZIP Code:**	**SS#:**
Cell Phone:	**Home Phone:**	**Work Phone:**	
Occupation:	**Employer:**		
How did you hear about our office?	**❑ Dr.**	**❑ Insurance Plan**	**❑ Hospital**
❑ Family	**❑ Friend**	**❑ Close to home/work**	**❑ Other**

INSURANCE INFORMATION

(Please give your insurance card and photo identification to the receptionist.)

Please indicate primary insurance:					
Insurance ID#:	**Group #:**	**Co-pay: $**			
Subscriber's name:	**Subscriber's Birth date: / /**				
Subscriber's S.S. #:	**Patient's relationship to subscriber:**	**❑ Self**	**❑ Spouse**	**❑ Child**	**❑ Other**
Name of secondary insurance:	**Subscriber's name:**				
Group #:	**Policy #:**				

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		
Home phone #:	**Work phone #:**	**Relationship:**

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Preferred Pharmacy Name	**Phone:**
Address/Location:	
Preferred Laboratory:	**Phone:**
Address/Location:	
May we call you at home? Yes No	**May we send a yearly recall to your home? Yes No**
May we leave a message at your home? Yes No	**May we call you at work? Yes No**
May we leave a message on your cell? Yes No	**May we obtain your Medication History? Yes No**
Health Communication Preferences: (please circle)	
Health Notifications: Email Phone Text Message	**Appointments: Email Phone Text Message**
Announcements: Email Phone Text Message	**Billing: Email Phone Text Message**
You may release / disclose information to:	**Please Circle: All Medical Info Limited to: _____**
Name:	**Relationship:** **Phone:**

Name:	**Relationship:**	**Phone:**
Name:	**Relationship:**	**Phone:**
This Authorization will expire on: _____		

I acknowledge and agree to adhere to the Notice of Privacy Practices as required by federal and state guidelines. I understand I may request and review a copy of these Practices at any time from the office staff. I permit the release of my pharmacy information and the release of any information, including my medical records, that may be requested by my insurance company to process any claims or as I have indicated above.

Patient/Guardian signature	*Date*

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I have completed this form and certify that I am the patient or duly authorized agent of the patient. I authorize the providers of Sarah B.Kline, MD Women's Health Care LLC to provide medical care and treatment for me. I understand that any overpayment I make will be refunded if the credit amount is over $24.99. Otherwise, the credit will be held for 18 months for future balances unless a request for refund is received.

I hereby authorize payment of benefits to be made directly to Sarah B.Kline, MD Women's Health Care LLC and/or any of the providers individually. I understand, as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service or statement and billing fees may be assessed.

Patient/Guardian signature	*Date*
Printed Name:	*Relationship:*

Dear Patients,

Our medical providers are participating in a government program that encourages the adoption of electronic health records. This technology is supposed to lead to reduced health care costs but it will also improve the quality of your care and our ability to communicate with you, our patients. As part of this program, the government requires us to record the following demographic information about you:

☐ Preferred language ☐ Race ☐ Ethnicity ☐

The U.S. Centers for Disease Control and Prevention (CDC) provides the options for the race and ethnicity fields that match the data collection standards defined by the U.S. Office of Management and Budget (OMB) and the U.S. Bureau of the Census (BC). We maintain secure records and assure you that this information will remain confidential. You can help us by reviewing the list of options below and providing your race and ethnicity information during registration or check-in. If you do not wish to provide this information, you may simply decline.

Thank you for your assistance!

Please identify your Race from the following CDC-defined options:

☐ African	☐ African American	☐ Alaska Native	☐ American Indian
☐ American Indian or Alaska Native		☐ Arab	☐ Asian
☐ Asian Indian	☐ Bahamian	☐ Bangladeshi	☐ Barbadian
☐ Bhutanese	☐ Black	☐ Black or African American	☐ Burmese
☐ Cambodian	☐ Chinese	☐ Dominica Islander	☐ Dominican
☐ European	☐ Filipino	☐ Haitian	☐ Hmong
☐ Indonesian	☐ Iwo Jiman	☐ Jamaican	☐ Japanese
☐ Korean	☐ Laotian	☐ Madagascar	☐ Malaysian
☐ Maldivian/N African	☐ Melanesian	☐ Micronesian	☐ Middle Eastern
☐ Native Hawaiian or Other Pacific Islander		☐ Nepalese	☐ Okinawan
☐ Other Race	☐ Pakistani	☐ Polynesian	☐ Singaporean
☐ Sri Lankan	☐ Taiwanese	☐ Thai	☐ Tobagoan
☐ Trinidadian	☐ Vietnamese	☐ West Indian	☐ White

Please identify your Ethnicity from the following CDC-defined options:

☐ Central American	☐ Cuban	☐ Dominican	☐ Hispanic or Latino/Spanish
☐ Latin American/Latin	☐ Mexican	☐ Not Hispanic or Latino	☐ Puerto Rican
☐ South American	☐ Spaniard		