CENTRAL CAROLINA OB|GYN

A DIVISION OF PIEDMONT HEALTHCARE FOR WOMEN

Patient Registration Form

Welcome to our practice. Please complete and return
to the receptionist with your insurance card.

Date ______________________ Acct#__________________________

Name ____
last first middle maiden

Address ____

City ______________________________ County__________________________ State ______________Zip___________________

Home Phone (   )_____________________________ Work Phone (   )___________________________________

Cell Phone (   )______________________________ Email Address ______________________________________

DOB _____________________________________Age ______________ Marital Status ____________________________

Social Security _______________________________________ Occupation _____________________________________

Employer ____ Employer Address _______________________________

Spouse/Parent _______________________________________ Social Security # _________________________________

Address ____ Home Phone _____________________________________

Employer ____ Work Phone _____________________________________

Alternate Contact (not living with you) ______________________ Home Phone _____________________________________

Work Phone _____________________________________

Referred By _____________________________ Primary Care Physician ____

Insurance Information

Over Please

It is the policy of Piedmont Healthcare for Women, PA Central Carolina Obstetrics and Gynecology, division to collect payment at the time services are rendered. If you have insurance with which we are contracted, applicable co-payments and/or co-insurance amounts are due at the time of service. The fees of this office are not based on the amount insurance will pay. The amount approved for payment on a particular procedure by your insurance company may be more or less than the fee charged by Piedmont Healthcare for Women, PA Central Carolina Obstetrics and Gynecology, division.

I understand that my medical insurance is an agreement between me and my insurance company to pay a specific amount for medical care. I also understand that full payment for my treatment remains exclusive financial responsibility, including charges not covered by my insurance carrier. I further understand that payment in full is due sixty (60) days after a claim has been submitted to my insurance carrier on my behalf. In addition, I understand that if my insurance requires pre-admission certification it will primarily be my responsibility to make sure this requirement is met.

I understand and agree to all statements contained herein and further understand that my failure to comply with this agreement may subject me to collection activity. If collection is pursued, I understand that I may be held responsible for the cost of recovery of bad debts, including collection and attorney fees.

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Signature of Patient or Responsible Party if Minor

I hereby authorize Piedmont Healthcare for Women, PA Central Carolina Obstetrics and Gynecology, division to furnish information to my insurance company regarding my examination(s). I also assign payment directly to Piedmont Healthcare for Women, PA Central Carolina Obstetrics and Gynecology, division for surgical and medical benefits.

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Signature of Patient or Responsible Party if Minor

Please note at least 24 hour advance notice
is required for the cancellation of appointments.
You may be required to pay an office visit charge if you do not
cancel within 24 hours of your scheduled appointment time.
(Please call Friday if a Monday appointment will not be kept.)

In addition, if more than two (2) appointments are missed,
you may be terminated as a patient from the practice.