

TODAY'S DATE: \_\_\_\_\_

**THE ADLER CENTER FOR WOMEN'S HEALTH  
PATIENT REGISTRATION**

PATIENT'S NAME FIRST		MIDDLE	LAST	
SOCIAL SECURITY NUMBER		DATE OF BIRTH	AGE	
HOME ADDRESS STREET	APT#	CITY	STATE/ZIP	HOME PHONE ( )
EMPLOYER	EMPLOYER ADDRESS		WORK PHONE ( )	
SPOUSE'S EMPLOYER	EMPLOYER ADDRESS		WORKPHONE ( )	
WHOM MAY WE THANK FOR REFERRING YOU?				
PRIMARY CARE PHYSICIAN (PCP)			PCP PHONE NO. ( )	

**EMERGENCY CONTACT**

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?		RELATIONSHIP
HOME PHONE _( )	WORK PHONE ( )	

**BILLING INFORMATION**

**\*PLEASE READ:**

**All charges are due at the time of service. All copayments must be made at the time of service. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage.**

PRIMARY INSURANCE COMPANY		SECONDARY INSURANCE COMPANY	
INS. CO. NAME		INS. CO. NAME	
ADDRESS		ADDRESS	
PHONE #		PHONE #	
I.D.# (SSN)	GROUP #	I.D.# (SSN)	GROUP #
SUBSCRIBER		SUBSCRIBER	
SUBSCRIBER EMPLOYER		SUBSCRIBER EMPLOYER	
EMPLOYER PHONE #		EMPLOYER PHONE #	
PATIENT'S RELATIONSHIP TO SUBSCRIBER		PATIENT'S RELATIONSHIP TO SUBSCRIBER	

**AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT**

I, \_\_\_\_\_, hereby authorize The Adler Center for Women’s Health to apply for benefits on my behalf for services rendered by The Adler Center for Women’s Health.

I request payment from \_\_\_\_\_ to be made directly to The Adler Center for Women’s Health. (INSURANCE COMPANY NAME)

I certify that the information reported herein is correct and further authorize the release of any necessary information including medical information for this or any other related claim from the billing agent for The Adler Center for Women’s Health to the above named insurance company as deemed necessary or as requested by the insurance company without notice.

I also permit a copy of this release to be used in place of the original.

I also realize that insurance is not a form of payment and all charges are my responsibility, with payment due in full at 90 days. I also understand that any changes in the above insurance information are to be reported by me within 10 workdays from the new effective date. Failure to do so releases The Adler Center for Women’s Health and/or his agents from our billing agreement and payment becomes due at the date of service.

**In the event that my account is placed in the hands of any attorney for collection, I agree to pay all costs and expenses, including a reasonable attorney’s fee related to the collection thereof.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(PATIENT’S SIGNATURE)

Patient Information Reverification:

Office Initials _____	Date _____	Patient Initials _____	Date _____
Office Initials _____	Date _____	Patient Initials _____	Date _____
Office Initials _____	Date _____	Patient Initials _____	Date _____