

Women's Health Care of Western Colorado

Patient Registration

Patient Name: _____
Last First MI Maiden Name

DOB: _____ SS# _____

ADDRESS: _____
Street/Box City State Zip

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Marital Status: M S W D (Circle one) Preferred Language _____

Family Physician: _____ Referred By: _____

Race: American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White Other _____

Ethnicity: (please circle one) Hispanic or Latino Non Hispanic or Latino

Occupation: _____ Employer: _____

Primary Insured: _____ Relationship: _____
(If Not Patient)

Address: _____
Street/Box City State Zip

DOB: _____ SS# _____ Phone: _____

Employed by: _____ Work Phone: _____

Insurance Carrier: _____ Group #: _____ Subscriber #: _____

Secondary Insurance _____ Group #: _____ Subscriber #: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone #: _____

I UNDERSTAND THAT I AM THE RESPONSIBLE PARTY FOR SERVICES RENDERED. IF MY INSURANCE COMPANY IS BILLED, I AUTHORIZE WOMEN'S HEALTH CARE OF WESTERN COLORADO TO FURNISH INFORMATION TO MY INSURANCE COMPANY CONCERNING SERVICES PROVIDED, AND I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO WOMEN'S HEALTH CARE OF WESTERN COLORADO. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY.

SIGNED: _____ DATE: _____
PATIENT/PARENT OR GUARDIAN



Documentation of Good Faith Efforts Notice of Privacy Practices & Notice of Breach

Patient Name: _____

Patient Date of Birth: _____

Patient's Acknowledgement of Receipt of Privacy Practices and Notice of Breach

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 01/2013.

Signature of Patient/Patient Representative

Date

Relationship to Patient

(for use when acknowledgment cannot be obtained from the patient)

The patient presented to the Practice on _____ and as a new patient/interested patient, was provided with a copy of Covered Entity's Notice of Privacy Practices. The new patient/interested patient, if any, are/were directed to the Practice's public posting of the complete *Women's Health Care of Western Colorado, P.C., Notice of Privacy Practice, and Breach Notification*, which is conspicuously posted in the patient waiting areas. A good faith effort has been made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:

- The patient had a medical emergency, and an attempt to obtain the Acknowledgment will be made at the next available opportunity.
- Other reason (describe below):

Signature of Employee Completing Form: _____

Date Signed: _____