REGISTRATION UPDATE FORM

Patient Information

Last Name: ______________________ First Name: ____________________ Today's Date: ________

Other Name: ______________________ Date of Birth: ____________

Address (street): ______________________________ City, State, Zip: ________________________

Email Address: ______________________________Home Phone:___________________________

Cell Phone:______________________Work Phone:___________________________Ext ________

PCP: ______________________________PCP Telephone # ______________________________

Birth Sex: ☐ Male ☐ Female **Gender Identity:** ☐ Male ☐ Female ☐ Genderqueer, neither exclusively male nor female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Pharmacy Update Information

Pharmacy Name: ____ ☐ Local ☐ Mail away

Address: ____ City, State, Zip: __________________

Pharmacy Name: ____ ☐ Local ☐ Mail away

Address: ____ City, State, Zip: __________________

Insurance Information

PRIMARY CARRIER NAME: ________________________________

ID/Cert #: ______________________ Group/Plan #: _____________ Effective Date: ___________

SECONDARY CARRIER NAME:______________________________

ID/Cert #: ______________________ Group/Plan #: _____________ Effective Date: ___________

Emergency Contact

Name:__________________________Relationship: _________________Phone:_________________

Electronic Communications

Email: I understand Axia will **not** share my email address with any third parties. My address will be used to communicate important announcements about my care center or provider, such as office closings, changes in services, and other non-clinical announcements pertaining to Axia or my care center. Axia offers secure electronic communications between patients and their office via the Patient Portal.

☐ Yes, I want to participate. Please use the email address above. ☐ No, I do not wish to participate.

Automated Reminders: Axia Women's Health offers automated reminders via text messages or automated calls. If I choose to participate, I understand my cell phone listed above will be used.

☐Yes, I agree to participate. (Please choose one method) ☐ Text messages ☐ Voice calls

☐No, I **do not** wish to participate.

I agree that Axia Women's Health and/or it's agents may contact me by cell phone, including via text messages or automated calls, which may result in charges to me.

Medical Chaperone

I request a female chaperone to be present during my examination? ☐ Yes ☐ No ☐ Other (family member, partner, etc. will be present)

Patient Signature

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.

Patient Signature:____________________________________ Date: _____________

Axia Women's Health

Patient's Name: ______________________________ DOB: ____________

Authorization for Treatment & Payment of Medical Benefits
Patient Financial Responsibility

Thank you for choosing our practice, an Axia Women's Health Care Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice.

Use of Photography

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

Patient Financial Responsibilities

- I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing my contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards. Patient Responsibility and Benefit information provided by Axia Women's Health are based on information provided by your insurer at the time of service. Axia is not responsible for the accuracy of this information. ACTUAL AMOUNT DUE TO AXIA WILL BE PROVIDED ONCE CLAIM IS ADJUDICATED BY PAYER.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
  - Charge for returned checks.
  - Charge for the copying and distribution of patient medical records.
  - Charge for forms completion.
  - Charge for missed appointments.

Patient Authorizations

- By my signature below, I hereby authorize the practice, an Axia Women's Health Care Center, to release medical and other information to the necessary insurance companies and third-party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, an Axia Women's Health Care Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

____

Signature of Patient or Guardian Date

Axia Women's Health

HIPAA
Acknowledgments and Authorizations

I. HIPAA Notice of Privacy Practices

Patient Acknowledgment

Axia is required by law to maintain the privacy of protected health information and provide individuals with notice of their legal duties and privacy practices with respect to protected health information. If I have any questions, I understand I can speak with the HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgment that I have been given the option of receiving a copy or been afforded an opportunity to review Axia's Notice of Privacy Practices:

Print Name: ______________________ Date of Birth: __________ Date: ______________

Signature: ______________________

II. Authorization for use or Disclosure of Health Information

Patient Contact Information

I authorize **brief messages** with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize **extended messages** with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐Work

Restrictions/Instructions: ______________________________________

Release of Medical History and Treatment Information

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

☐Please use my emergency contact on the patient demographic form.

Name: ________________ Relationship: ______________ Ph #: ____________

Name: ________________ Relationship: ______________ Ph #: ____________

The above individual(s) may receive information across all Axia care centers unless otherwise noted: ______________

Release of Billing Information

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

☐Please use my emergency contact on the patient demographic form.

Name: ________________ Relationship: ______________ Ph #: ____________

Name: ________________ Relationship: ______________ Ph #: ____________

The above individual(s) may receive information across all Axia care centers unless otherwise noted: ______________

Parent / Guardian Information

Contact: ____________________ Relationship to You: ____________________

Home Phone: ____________________ Alt. Phone: ____________________

Contact: ____________________ Relationship to You: ____________________

Home Phone: ____________________ Alt. Phone: ____________________

Patient Acknowledgment

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance with the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office address. My revocation will be effective once received by the practice, an Axia Women's Health Care Center.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name: ______________________ Date: ______________

Signature: ______________________ Relationship: ______________

Additional Authorizations

I request a female chaperone to be present during my examination? ☐ Yes ☐ No ☐ Other ______________

Patient Bill of Rights
South Jersey Fertility Center

Each patient receiving service in an ambulatory care facility shall have the following rights and responsibilities:

- Patient to receive considerate and respectful care consistent with sound nursing and medical practices.
- Patient to be informed of the name of the physician responsible for coordinating their care.
- Patient may obtain from the physician - complete, current information concerning her diagnosis, treatment, and prognosis in terms they can reasonably be expected to understand.
- Patient to receive from the physician information necessary to give informed consent prior to the start of any procedure or treatment.
- Patient may refuse treatment to the extent permitted by law and to be informed of the medical consequences of such action.
- Patient to be provided privacy to the extent consistent with providing adequate medical care to the patient.
- Patient is provided privacy and confidentiality of all records pertaining to the patient's treatment, except as otherwise provided by law or third party payment contract, and access to those records.
- Patient expects that within its capacity, the facility will make reasonable response to the patient's request for services, including the services of an interpreter in a language other than English.
- Patient will be informed by their physician of any continuing health care requirements which may follow discharge and to receive assistance from the physician and appropriate facility staff in arranging for required follow-up care after discharge.
- Patient will be informed by the facility of the necessity of transfer to another facility prior to the transfer and of any alternatives to it which may exist.
- Patient will be informed, upon request, of other health care and educational institutions that the facility has authorized to participate in the patient's treatment.
- Patient will be advised if the facility proposes to engage in or perform human research or experimentation and to refuse to participate in these projects.
- Patient may examine and receive an explanation of the patient's bill, regardless of the source of payment, and to receive information or be advised on the availability of sources of financial assistance to help pay for the patient's care, as necessary.
- Patient may expect reasonable continuity of care.
- Patient to receive treatment without discrimination as to race, age, religion, sex, national origin, or source of payment.
- Patient may receive a signed copy of the "Patient Bill of Rights" and the original will be maintained in patient's medical record.

______________________________ ______________

Patient's Signature Date