PATIENT REGISTRATION FORM

LOUISE H. CONNOLLY, M.D.

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST • FIRST • MIDDLE) ☐ MS ☐ MR	DATE OF BIRTH / /	AGE	MARITAL STATUS ☐ S ☐ M	TODAY'S DATE / /
ADDRESS (STREET • CITY • STATE • ZIP)	HOME PHONE ( )		OK TO LEAVE PERSONAL MESSAGE ☐ YES ☐ NO	
NAME OF EMPLOYER / OCCUPATION	EMAIL	OK TO EMAIL ☐ YES ☐ NO	WORK PHONE / EXTENSION ( )	OK TO LEAVE PERSONAL MESSAGE ☐ YES ☐ NO
EMPLOYER ADDRESS (STREET • CITY • STATE • ZIP)	SOCIAL SECURITY NO.		CELL PHONE ( )	OK TO LEAVE PERSONAL MESSAGE ☐ YES ☐ NO
SPOUSE'S NAME (LAST • FIRST • MIDDLE)	DATE OF BIRTH / /	NAME OF EMPLOYER	WORK PHONE ( )	
NEAREST FRIEND NOT LIVING WITH YOU	PHONE NO. ( )	NEAREST RELATIVE NOT LIVING WITH YOU	PHONE NO. ( )	
IN CASE OF EMERGENCY CONTACT 〉 NAME		RELATIONSHIP	PHONE NO. ( )	
WHOM MAY WE THANK FOR REFERRING YOU TO US?	FAMILY PHYSICIAN	PHONE NO. ( )	**NO CASH ACCEPTED**	

INSURANCE INFORMARTION

PRIMARY INSURANCE CARRIER	SECONDARY INSURANCE CARRIER	**PLEASE ATTACH CARD(S)**

We are committed to providing you with the best possible care. We are anxious to help you receive your maximal allowable benefits, but we need your assistance and understanding of payment processing. You must realize that:

1. Your insurance is a contract between you, your employer and the insurance company. WE ARE NOT PARTY TO THAT POLICY. YOU NEED TO UNDERSTAND THAT!
2. Not all services are covered benefits in all contracts. Some companies arbitrarily select certain services they will not cover. There are thousands of different plans.
3. It is your responsibility to understand your deductible, amount met, your preferred laboratory and your general insurance coverage. Dr. Connolly cannot and is not responsible for reducing or reversing her own or laboratory charges once incurred. All abnormal ultrasounds, and any indicated ultrasounds incur a charge.

FINANCIAL AGREEMENT

I accept full financial responsibility for all charges billed and guarantee to pay all such charges. I'm aware that accounts are due and payable upon presentation of statement. I understand that if any bill(s) remains unpaid (90) days after the bill(s) are due, I will be sent to collections.

SIGNATURE _____ DATE _____ RELATIONSHIP (IF OTHER THAN PATIENT) _____

CANCELLATION POLICY We require at least a 24 hour notice for cancellations. Cancellations within 24 hours or no shows will result in a $50.00 charge.

_____ INITIAL

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses and those health care providers that conduct certain health care transactions electronically. The rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections. Our **Notice Of Privacy Practices** describes in greater detail how your health information may be used and disclosed, and how you can access your information.

☐ **I would like a copy of the Notice Of Privacy Practices** ☐ **I do not want a copy of the Notice Of Privacy Practices**

SIGNATURE _____ DATE _____ RELATIONSHIP (IF OTHER THAN PATIENT) _____

MEDICARE PATIENTS
Medicare only covers PAP SMEARS every 2 years. However, it does cover any other patient problems you may have, so please come in anytime!

Normal results will be available by request after received. However, ALL ABNORMAL RESULTS require a face to face meeting with Dr. Connolly.

_____ INITIAL

If you refuse to come in, you absolve Dr. Connolly of any responsibility for the consequences of these abnormal labs. _____

SIGNATURE