Casper Women's Care, PC

770East 2ND Street
Casper WY, 82601
Phone: 307-237-5510
Fax: 307-237-0607

Annual Registration Update

Name_____
Last First Middle Initial

SSN_____ DOB_____

Mailing Address_____

City_____ State_____ Zip Code_____

Phone Number_____ Cell Home Work Other

Preferred Method of Contact_____ Okay to leave messages? _____

Emergency Contact Person_____ Phone Number_____

Relationship to Patient_____

Race _____ Ethnicity _____

Are you employed? Yes No Place of employment_____

Business address_____Work Phone Number_____

As of July 1st, 2016 you have the ability to access your personal medical records, ask questions, refill medications, or request an appointment from our online patient portal, and avoid paperwork to be done in our office; please provide an email address so we can send you the start-up information:

Do you have Medical Insurance? Yes No PLEASE COMPLETE EVEN IF WE GOT A COPY OF YOUR CARD!

Name of Primary Insurance Co.: _____

Policy ID: _____ Group Number: _____

Person Responsible for Policy: _____ Relationship to Patient: _____

Birthday: _____ Social Security Number: _____ Employer: _____

Responsible Party's Address: _____ City: _____ State: _____ Zip: _____

Responsible Party's Primary Phone Number_____ Type: Cell Home Work Other

Name of Secondary Insurance Co.:_____

Policy ID: _____ Group Number: _____

Person Responsible for Policy: _____ Relationship to Patient: _____

Birthday:_____ Social Security Number:_____ Employer:_____

Responsible Party's Address:_____ City:_____ State:_____ Zip:_____

Responsible Party's Primary Phone Number:_____ Type: Cell Home Work Other

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Patient Photo

By providing my initials, Casper Women's Care, PC has my permission to take a photograph of my face and upper body. I understand that this picture will be used as another way to identify me on my personal record and will not be used in any other manner. I also understand that Casper Women's Care, PC will not release your information except for the reason listed above: _____.

Please Initial

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____,

Name of Insurance Company

and assign all insurance benefits, if any, to Casper Women's Care, PC. I acknowledge that these benefits may be otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not they are paid by insurance. I hereby authorize the named practice to release all information necessary to secure the payment benefits. I authorize the use of my signature on all insurance submissions. _____.

Please Initial

Financial Agreement

I, the undersigned client/guardian, agree to pay for all services rendered and/or goods sold to me or my ward immediately upon demand. I further agree that in the event of non-payment of any amounts due under this agreement, I will pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

Signature_____ Date_____