(307) 237-5510
Fax: (307) 237-0607
770 East 2nd Street
Casper, WY 82601

Annual Registration Update

Patient Information

Name____
Last First Middle Initial

SSN_______________________ DOB_______________________

Mailing Address____

City____________________ State__________ Zip Code____________

Phone Number______________________________ Cell Home Work Other

Email Address____

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______________

If you are interested in having the ability to access your personal medical records, ask questions, refill medications, or request an appointment from our online patient portal, please provide an email address so we can send you the start-up information:

____

Insurance Information

Name of Primary Insurance Co.__________________________________

Person Responsible for Policy__________________________________

Birthdate: ______________________ SSN: ______________________

Policy ID______________________________ Group Number______________

Name of Secondary Insurance Co.________________________________

Person Responsible for Policy__________________________________

Birthdate: ______________________ SSN: ______________________

Policy ID______________________________ Group Number______________

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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_________________________________