Comprehensive Women's Care

Obstetrics & Gynecology - Dr. Keith J. Reisler

Diplomate of the American Board of Obstetrics and Gynecology

REGISTRATION FORM

Legal Name: ______________________ Preferred Name: ______________________

DOB: ______________ Marital Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced

SS#: ______________ DL#: ______________ Email: ______________________

Address: ______________________ Home Phone: ______________

City: ______________ State: ______________ ZIP: ________ Mobile Phone: ______________

Employer: ______________________ Occupation: ______________________

Employer Address: ____

City: ______________ State: ______________ ZIP: ________ Work Phone: ______________

Spouse's/Parent Name: ____

DOB: ______________ SS#: ______________ DL#: ______________

City: ______________ State: ______________ ZIP: ________ Mobile Phone: ______________

Employer: ______________________ Occupation: ______________________

Employer Address: ____

City: ______________ State: ______________ ZIP: ________ Work Phone: ______________

Primary Insurance: ______________________ Name of Insured: ______________________

Address: ______________________ DOB: ______________

City: ______________ State: ______________ ZIP: ________ Phone: ______________

ID#/SS#: ______________________ Group #: ______________________

Secondary Insurance: ______________________ Name of Insured: ______________________

Address: ____

City: ______________ State: ______________ ZIP: ________ Phone: ______________

ID#/SS#: ______________________ Group #: ______________________

In Case of Emergency, Contact: ______________________ Relation To You: ______________

City: ______________ State: ______________ ZIP: ________ Phone: ______________

Pharmacy: ______________ Location: ______________ Phone: ______________

I assign all medical/surgical benefits to which I am entitled to attending physician. I authorize the release of medical information necessary to request reimbursement from insurance companies. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Consent to receive treatment: I hereby authorize the physician to treat myself or if a minor, my daughter, as deemed medically necessary.

Signature: ______________________________________ Date: ______________

PATIENT CONSENT FORM

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize Keith J. Reisler, MD to release and furnish on a confidential and a strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by Physicians, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's, PPO's, Managed Care Organizations, Indemnity Plans, Medicare/Medicaid or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions.

I also give my authorization to have a copy of my medical records delivered to a primary care physician or any other physician that is directly or indirectly responsible for my medical care or the payment thereof.

I also give my authorization for _______________ to talk to the office staff about my financial data and all medical information.

Patient's and/or Guardian Signature: ____

Date: _____/______/_____

* This authorization will remain in effect permanently.*

PATIENT'S RESPONSIBILITY

Signing of this form in no way implies that your insurance company will cover your visits with this office. Keith J. Reisler, MD and his employees cannot guarantee any information given to us by your insurance carrier regarding your benefits.

1. If you are not part of an HMO, PPO, Medicare/Medicaid, or Managed Choice Plan that your physician participates in, you will responsible for your bill at the time of service.

2. If you are part of a PPO plan and you have a deductible for services other than your regular office copay, you will be responsible for payment of said deductible.

3. If you are part of a Managed Choice or HMO plan, failure to obtain a valid referral from your Primary Care Physician (PCP) may result in no benefits being paid. You will be responsible for any non-payment from your insurance carrier.

Patient's and/or Guardian Signature: ____

Date: _____/______/_____