Just *for* Women
Health Solutions
Clark Physician Group
No One Cares Like Clark.

Registration Form

Primary Care Physician:______________________

Phone #:________________________

*Where did you learn about us?*____

Account #______________________________

Patient's Full Name____
(First) (Middle) (Last)

Patient's Date of Birth___________________ Age__________ SSN_______________________________

Patient's Address____
(Street) (City) (State) (Zip)

□ Married □ Single □ Divorced □ Widow

Responsible Party's Name_______________________________ E-mail____________________________________
(Parent, Guardian, or Spouse) *May we use your e-mail?* □*Yes* □ *No*

Patient Home Phone ___________________________________ Cell Phone____________________________________

May we use your answering machine or voice mail if you are not available? □ *Yes* □ *No*

Employer___________________________________ Employer's Phone Number_________________________________

Occupation of Patient_________________________ *May we call you at work?* □ *Yes* □*No*

(Please fill out completely)
Spouse or Parent's Name________________________
Social Security Number_________________________
Date of Birth__________________________________
Occupation___________________________________
Employer____________________________________
Employer's Phone Number________________________

(Please fill out completely)
Subscriber's Name______________________________
Relationship to Patient___________________________
Subscriber's Date of Birth_________________________
Subscriber's SSN________________________________
Subscriber's Employer____________________________

EMERGENCY CONTACT (NOT LIVING AT SAME ADDRESS AS PATIENT).........RELATIONSHIP...........PHONE #

Has any member of your immediate family been treated by our physicians before? □ Yes □ No

Religion (Optional):____

INSURANCE PRIMARY	INSURANCE SECONDARY

AUTHORIZATION (Please read and sign)

MEDICAID, MEDICARE I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related MEDICAID, MEDICARE claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to MEDICAID, MEDICARE for payment.

I request that payment under the medical insurance program be made to *Clark Physician Group, LLC,* on any bills for services furnished me by *Clark Physician Group, LLC.*

ALL INSURANCES, MEDICAID, MEDICARE

1. I hereby authorize treatment to me by *Just for Women Health Solutions*.
2. I hereby authorize *Just for Women Health Solutions* to furnish information to insurance carriers concerning my illness and treatment, and I hereby assign to the physician(s) all payments for medical services rendered to myself.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

3. I hereby authorize any physician, hospital, or medical facility to provide any medical information requested by *Just for Women Health Solutions.*
4. I hereby authorize copies of the above authorizations to be as valid as the original.
5. Any labs, x-rays, etc., will be billed by the provider of service not through this office.

Authorization: I hereby authorize payment directly to the provider of services, and I understand that I am financially responsible for charges not covered by this authorization.

Signature____ Date______________________________