Patient Registration Form

DOWNTOWN WOMEN
OB-GYN ASSOCIATES, LLP

568 Broadway, Suite 304 – New York, NY 10012
Tel: 212-966-7600 Fax: 212-925-8736

PATIENT LAST NAME:_____ PATIENT FIRST NAME: _____

DATE OF BIRTH:_____/_____/_____ Social Security #: _____/_____/_____ eCW ID #_____

Date_____

To All Patients of Downtown Women Ob-Gyn:

We appreciate and respect the trust you place in us to provide you with gynecologic and/or obstetric care and services.

Please understand that your benefit plan is an arrangement that involves you, your insurance carrier and your employer. Occasionally, gynecologic, pre-natal, and delivery care that you request from us is not covered by your plan or there is a deductible, co-payment, or co-insurance that you or we are not aware of at the time of your visit.

In order for our office to run smoothly and continue to offer you high quality care, we respectfully request that you sign below to authorize Downtown Women Ob-Gyn to keep your signature on file and charge your credit card for the balance of charges not paid or covered by insurance.
You will receive a courtesy call prior to our charging in excess of $250.00.

Thank you for your cooperation,

Downtown Women OB-GYN Associates, LLP

Card type: (please circle one): ●Visa ● MasterCard ●American Express ●Discover ●Flexcard

Name on Credit Card / Flex Card: _____

Please indicate both numbers.

Credit Card Number: _____

Expiration Date: _____
Security Code (3 digit code on back of card)_____
Billing Zip Code_____

Flex Spending Card Number: _____

Expiration Date: _____
Security Code (3 digit code on back of card)_____

Please note: Scheduled appointments not canceled by 5PM the prior business day are subject to a $40.00 no show fee.
Returned checks are subjected to a $10.00 returned check fee.

INSURANCE PLANS: ** Please list your Primary and Secondary Insurance Carriers and Give Cards to the Front Desk to Copy.
Primary Insurance:
PLAN NAME: _____ ID#: _____ GROUP:_____
CLAIMS ADDRESS: _____
PLAN PHONE #:( )_____-_____ POLICY HOLDER: ___ SELF ___ SPOUSE**(Complete Below)** ___ PARENT
SPOUSE NAME: _____ SPOUSE SOCIAL: _____-_____-_____
SPOUSE EMPLOYER: _____ SPOUSE DOB: _____/_____/_____
Secondary Insurance:
PLAN NAME: _____ ID#: _____ GROUP:_____
CLAIMS ADDRESS: _____

ASSIGNMENT AND RELEASE: I, the undersigned, certify that the above information is correct and assign all payments made on my behalf by my insurance carrier(s) directly to Downtown Women OB-GYN Associates, LLC and its physicians / allied health practitioners. I hereby authorize the release of any and all information necessary to obtain payment of benefits for services provided to me. I understand that I am responsible for any and all charges not covered by my insurance carrier due to the lack of such benefits within my plan or due to my lack of coverage for any reason. I understand that I am also responsible for any co-insurances, deductibles and co-payments.
**** I also acknowledge receipt of the HIPAA Notice of Privacy Practices for this practice.**

_____ _____ _____
Patient Signature Relationship to Patient, if not Patient Date