



Your Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Last Menstrual Period \_\_\_\_\_

Please list all allergies and type of reaction: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all medications that you take, as well as quantity and frequency:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



REGISTRATION UPDATE FORM

Patient Information

Last Name: First Name: Today's Date:
Other Name: Date of Birth:
Address (street): City, State, Zip:
Email Address: Home Phone:
Cell Phone: Work Phone: Ext
PCP: PCP Telephone #
Birth Sex: Gender Identity:
Marital Status:

Pharmacy Update Information

Pharmacy Name: Local Mail away
Address: City, State, Zip:
Pharmacy Name: Local Mail away
Address: City, State, Zip:

Insurance Information

PRIMARY CARRIER NAME:
ID/Cert #: Group/Plan #: Effective Date:
SECONDARY CARRIER NAME:
ID/Cert #: Group/Plan #: Effective Date:

Emergency Contact

Name: Relationship: Phone:

Electronic Communications

Email: I understand Axia will not share my email address with any third parties. My address will be used to communicate important announcements about my care center or provider, such as office closings, changes in services, and other non-clinical announcements pertaining to Axia or my care center. Axia offers secure electronic communications between patients and their office via the Patient Portal.

Yes, I want to participate. Please use the email address above. No, I do not wish to participate.

Automated Reminders: Axia Women's Health offers automated reminders via text messages or automated calls. If I choose to participate, I understand my cell phone listed above will be used.

Yes, I agree to participate. (Please choose one method) Text messages Voice calls

No, I do not wish to participate.

I agree that Axia Women's Health and/or its agents may contact me by cell phone, including via text messages or automated calls, which may result in charges to me.

Medical Chaperone

I request a female chaperone to be present during my examination? Yes No Other (family member, partner, etc. will be present)

Patient Signature

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.

Patient Signature:

Date:

Axia Women's Health  
**HIPAA**  
**Acknowledgments and Authorizations**

**I. HIPAA Notice of Privacy Practices**

***Patient Acknowledgment***

Axia is required by law to maintain the privacy of protected health information and provide individuals with notice of their legal duties and privacy practices with respect to protected health information. If I have any questions, I understand I can speak with the HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgment that I have been given the option of receiving a copy or been afforded an opportunity to review Axia's Notice of Privacy Practices:

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**II. Authorization for use or Disclosure of Health Information**

***Patient Contact Information***

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext: \_\_\_\_\_

I authorize **brief messages** with medical information to be left on voicemail at (check all that apply):  Home  Cell  Work

I authorize **extended messages** with medical information to be left on voicemail at (check all that apply):  Home  Cell  Work

Restrictions/Instructions: \_\_\_\_\_

***Release of Medical History and Treatment Information***

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Please use my emergency contact on the patient demographic form.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

The above individual(s) may receive information across all Axia care centers unless otherwise noted: \_\_\_\_\_

***Release of Billing Information***

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

Please use my emergency contact on the patient demographic form.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

The above individual(s) may receive information across all Axia care centers unless otherwise noted: \_\_\_\_\_

***Parent / Guardian Information***

Contact: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

Contact: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

***Patient Acknowledgment***

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance with the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office address. My revocation will be effective once received by the practice, an Axia Women's Health Care Center.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

***Additional Authorizations***

I request a female chaperone to be present during my examination?  Yes  No  Other \_\_\_\_\_

Axia Women's Health

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Authorization for Treatment & Payment of Medical Benefits  
Patient Financial Responsibility**

Thank you for choosing our practice, an Axia Women's Health Care Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

**Authorization for Treatment & Payment of Medical Benefits**

I give permission to the practice to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice.

**Use of Photography**

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

**Patient Financial Responsibilities**

- + I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- + You will assist me by billing my contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- + I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards. Patient Responsibility and Benefit information provided by Axia Women's Health are based on information provided by your insurer at the time of service. Axia is not responsible for the accuracy of this information. ACTUAL AMOUNT DUE TO AXIA WILL BE PROVIDED ONCE CLAIM IS ADJUDICATED BY PAYER.
- + I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
  - ⊕ Charge for returned checks.
  - ⊕ Charge for the copying and distribution of patient medical records.
  - ⊕ Charge for forms completion.
  - ⊕ Charge for missed appointments.

**Patient Authorizations**

- + By my signature below, I hereby authorize the practice, an Axia Women's Health Care Center, to release medical and other information to the necessary insurance companies and third-party payers required for payment of rendered health services.
- + By my signature below, I hereby authorize assignment of financial benefits directly to the practice, an Axia Women's Health Care Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

**I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:**

Signature of Patient or Guardian \_\_\_\_\_

Date \_\_\_\_\_



PREMIER  
WOMEN'S HEALTH  
OF SOUTH JERSEY

axiawh.com

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Dear Patient:

The State of New Jersey mandates that every physician office document any barrier to care including physical impairments, cultural and linguistic needs in their medical records.

**Please assist us by answering the following questions:**

Do you have any impairment – Visual, hearing, speech, learning, physical or language/cultural barrier?

What language do you speak, read or write?

Do you have any religious or culture customs that the provider should know about?

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

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**Mullica Hill** | 34 Colson Lane, Mullica Hill, NJ 08062 | P: 856-223-8930 F: 855-475-6191  
**Elmer** | 340 West Front Street, Hofmann Professional Building, Suite 201, Elmer, NJ 08318 | P: 856-223-8930 F: 855-475-6191  
**Woodbury** | 603 North Broad Street, Suite 300, Woodbury, NJ 08096 | P: 856-223-8930 F: 855-475-6191  
**Woolwich** | 100 Lexington Road, Building 100, Woolwich Township, NJ 08085 | P: 856-223-8930 F: 855-475-6191