



Patient Registration Form

Today's Date: ____ / ____ / ____

Last Name: _____ First Name: _____ Middle: _____

Address: _____ APT# _____

City _____ State: _____ Zip _____

Home Ph: (____) _____ Work Ph: (____) _____ Other Ph: (____) _____

SSN: _____ - _____ - _____ Date of Birth: ____ / ____ / ____ Age: _____

Status: Single Married Widow Divorced Sex: Male Female Occupation: _____

Employer: _____ Employer Phone: (____) _____

Emergency Contact Person: _____ Phone: (____) _____

Email: _____

Insurance Information

(If insurance information is incorrect or incomplete, the patient will be responsible for bill)

Primary Insurance Name: _____ Phone: (____) _____

Address: _____ City/State _____ Zip _____

Subscriber Name: _____ Employer: _____

SSN: _____ - _____ - _____ Date of Birth: ____ / ____ / ____ Relationship to patient _____

ID#: _____ Group #: _____

Secondary Insurance Name: _____ Phone: (____) _____

Address: _____ City/State _____ Zip _____

Subscriber Name: _____ Employer: _____

SSN: _____ - _____ - _____ Date of Birth: ____ / ____ / ____ Relationship to patient _____

ID#: _____ Group #: _____

Guarantor Information (patients age 18 and under)

Last Name: _____ First Name: _____ Middle: _____

Address: _____ APT# _____

City _____ State: _____ Zip _____

Home Ph: (____) _____ Relationship to Patient: _____

SSN: _____ - _____ - _____ Date of Birth: ____ / ____ / ____

Status: Single Married Widow Divorced Sex: Male Female Occupation: _____

Employer: _____ Employer Phone: (____) _____

Parent / Guardian Signature if Patient is Under 18: _____

Consent/Release/Authorization

The insurance information listed on page one is current and correct. If any information is incorrect, I understand that I will be held responsible for any unpaid balance. I also understand and I agree that I will be responsible for any collection or legal fees associated with the collection of overdue balances that are my responsibility. It is my responsibility to notify Healthy Woman of any changes that occur in my insurance coverage.

I authorize Healthy Woman to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payment for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance. In order to evaluate my present health status, I hereby consent, voluntarily, to undergo examination and necessary treatment by Healthy Woman. I authorize Healthy Woman to disclose my health information for treatment, payment and health care operations. I have read and understand the above and hereby, voluntarily give my consent and authorization.

Patient Signature _____ Date ____ / ____ / ____



Joseph Cipriano, M.D. FACOG
Rebecca Cipriano, M.D. FACOG
Susan Pacana, M.D. FACOG
Neeti Misra, M.D. FACOG
Elizabeth Scheff, M.D. FACOG
Borislava Burt- Libo DO
Julie Leizer, M.D.

www.healthywomanusa.com

Stephanie Serrentino
Executive Director

Colleen Behrens
Office Manager

Grace Kasnowski
Prenatal Coordinator

Freehold
312 Professional View Drive
Building 300, Second Floor
Freehold, NJ 07728
Ph: (732) 431 - 1616
Fax: (732) 866 - 7962



Colts Neck
340 Highway 34
Suite D-2
Colts Neck, NJ 07722
Ph: (732) 431 - 1616
Fax: (732) 866 - 7962

Medical Services Waiver

I understand that I am presenting myself in the office today for medical services to be performed. While many insurance companies cover the services that may be performed such as an annual exam (including pap smear, breast exam, other age appropriate screenings), biopsies, colposcopies and injections, I have been informed that some insurance companies do not. If my insurance company does not pay Healthy Woman for the services performed today I understand that any charges incurred during my exam will be my financial responsibility.

I understand that I will also be responsible for any copay or coinsurance payment due to Healthy Woman at the time of service, per the requirements of my health insurance plan contract.

I also understand that I will be responsible for payment of charges in full if I do not have any health insurance coverage.

Lastly, I understand that if I require a referral or preauthorization for Healthy Woman's services or any additional services recommended by Healthy Woman (including but not limited to radiology and lab work), I am responsible for either obtaining the correct referral OR notifying the office within 48 hours of the date of service to obtain an authorization. If I fail to do so, I will be responsible for the balances billed by Healthy Woman or outside parties for these services.

X _____
Patient Signature Patient Printed Name

If patient is under 18:

X _____
Parent / Guardian Signature Patient Printed Name

____/____/____
Date



Joseph Cipriano, M.D. FACOG
Rebecca Cipriano, M.D. FACOG
Susan Pacana, M.D. FACOG
Neeti Misra, M.D. FACOG
Elizabeth Scheff, M.D. FACOG
Borislava Burt- Libo DO
Julie Leizer, M.D.

www.healthywomanusa.com

Stephanie Serrentino
Executive Director

Colleen Behrens
Office Manager

Grace Kasnowski
Prenatal Coordinator

Freehold
312 Professional View Drive
Building 300, Second Floor
Freehold, NJ 07728
Ph: (732) 431 - 1616
Fax: (732) 866 - 7962



Colts Neck
340 Highway 34
Suite D-2
Colts Neck, NJ 07722
Ph: (732) 431 - 1616
Fax: (732) 866 - 7962

Authorization for Release of Protected Health Information

I authorize the staff and/or physicians at Healthy Woman to discuss my healthcare, diagnosis, test results, procedures, prognosis, insurance and billing information with the following person(s) for the purpose of my treatment or payment of services rendered *:

Name of designated person Relationship to patient

Name of designated person Relationship to patient

☐ I DO NOT wish to designate any person(s) *

**Please note for children under 18 years of age, information will be released to the parent or legal guardian.*

I authorize the release of my Protected Health Information to the following physician(s) or facility(s) upon request of the physician(s) or facility(s) for the purpose of my treatment:

Name of designated Physician or Facility Type of Physician or Facility

Name of designated Physician or Facility Type of Physician or Facility

☐ I DO NOT wish to designate any physician(s) or facility(s)

I understand that in order to ensure continuation of care, the staff and/or physicians at Healthy Woman may need to leave messages on the answering machine at my home or with any individual(s) who may answer my home phone. These messages may include but are not limited to: appointment confirmations, lab results, radiology results, pathology results, etc.

☐ I DO wish to have messages left ☐ I DO NOT wish to have messages left
☐ I DO NOT wish to have email sent

I also understand that by designating the above individual(s) or facility(s), I am allowing my Protected Health Information (medical records/ information) to be discussed or released to them. I know that this is my personal choice and I have not been forced to designate any individual(s) or facility(s) if I have chosen not to.

Patient Printed Name X Patient Signature

Date

Privacy Practices Acknowledgement

I have reviewed / received the Notice of Privacy Practices for Healthy Woman

Patient Printed Name X Patient Signature

Date