Women's Health Center
Patient Information Sheet

Home Phone (_____)_____ Cell Phone (_____) _____

Patient_____ _____
First Name **Last Name**

Street Address _____**City**_____State_____

Zip_____

Birthday_____ Age_____ **Social Security #:** _____

__ Single __Married __Widowed __Separated __Divorced

Pharmacy Name_____Phone # _____Primary Care Physician _____

Patient's Employer (if child, mother's name and employer)
Employer_____
Business Address_____Occupation_____Phone_____

Spouse's Name (if child, father's name and employer) _____Employer_____
Business Address_____Occupation_____Phone_____

Who is responsible for this account _____Relationship to Patient _____
Social Security# _____Spouse's Social Security#_____

Do you have Medical Insurance? __Yes __No
Name of Primary Insurance _____

In case of an emergency, who should be notified? _____Relationship to Patient _____Phone _____

DISCLOSURE PROTECTED HEALTH INFORMATION

I acknowledge that I have received a copy of Women's Health Center notice of Privacy Practices. I hereby authorize the following people to be made aware of my test results, appointment times, medical information and patient account status. I understand that if someone inquires about any of the information listed above and is **NOT** on this consent, information will **NOT BE RELEASED.**

_____ _____

NAME/RELATIONSHIP TO PATIENT **NAME/RELATIONSHIP TO PATIENT**

_____ _____

NAME/RELATIONSHIP TO PATIENT **NAME/RELATIONSHIP TO PATIENT**

FINANCIAL AGREEMENT-PLEASE INITIAL EACH STATEMENT

____I understand that payment is due and expected in full at the time services are rendered unless other arrangements have been made **PRIOR** to this appointment. This includes deductibles, co-payments, co-insurance, and non-covered charges.

____I understand that my insurance will be filed, as a courtesy, and that I am responsible for any and all balances not covered by my Insurance plan. I also understand that all insurance cards, both primary and secondary, must be given at the time services are rendered. If insurance cards are not given at the time of initial visit, then the practice has no obligations to file claims on my behalf. If cards are not given than any filing with the insurance will be my responsibility.

____I understand that my insurance may disallow charges as above "reasonable and customary" and that these amounts are my responsibility and **NOT** a contractual write-off.

____I understand that I am fully responsible for any referrals or prior authorizations required by my insurance company for payment to be made on my claims. If these are not obtained and payment for service is denied from my insurance carrier, all balances will be my responsibility.

____I understand that I will be responsible for any attorney's fees, court costs, and/or collection fees added to this account if it becomes necessary to refer my account to outside collections.

AUTHORIZATION:

I authorize Women's Health Center to release any medical information pertaining to my care to my referring physician, any physician I am referred to from this office, and any other physician/office participating in my care. I authorize treatment from this office and payment of medical benefits to the physician/supplier for those services rendered not to exceed the total billed charges for those services. I authorize the release of any information necessary to process insurance claims and I **certify** the information contained herein is correct. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment of benefits apply.

_____ _____

PATIENT'S SIGNATURE DATE

_____

PATIENT'S NAME (PLEASE PRINT)

ATTENTION:

To help us file prompt and accurate claims, please list **ALL** of your insurance coverage, including policies covered by a spouse, partner, parent, Medicaid, Medicare, or legal guardian. **You are required to reveal ALL primary, secondary and tertiary insurance at the time of service. You may be held responsible for claims that are denied as a result of incomplete insurance disclosure. Initial_____**