

Women's Health Specialists

Name _____			Account # _____
First	Middle	Last	
Home Address _____			Phone Number _____
Street Address		City	Zip
Social Security # _____			Date of Birth _____
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Minor <input type="checkbox"/> Domestic Partner			Cell Number _____
Your Employer _____			Work Number _____
Work Address _____			Occupation _____
Street Address		City	Zip
Emergency Contact _____			Relationship _____
Address _____			Phone Number _____
Street Address		City	Zip
How did you hear of our group? _____			Family Doctor _____

Insurance Info – Primary <input type="checkbox"/> HMO Med Group _____ <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> EPO ID# _____		
Insured Person's Name _____		Date of Birth _____ SS# _____
Relationship to the Patient _____	Eff. Date _____	Group # _____ co-pay _____
Insurance Company Name _____ Address _____		
Insurance Info – Secondary <input type="checkbox"/> HMO Med Group _____ <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> EPO ID# _____		
Insured Person's Name _____		Date of Birth _____ SS# _____
Relationship to the Patient _____	Eff. Date _____	Group # _____ co-pay _____
Insurance Company Name _____ Address _____		

Medical information can be discussed with: <input type="checkbox"/> Patient Only <input type="checkbox"/> Family member or friend _____ <input type="checkbox"/> Physician <input type="checkbox"/> Other _____	Detailed Messages regarding test results can be left on answering machine <input type="checkbox"/> Yes Phone Number _____ <input type="checkbox"/> No
E-MAIL: _____	

Truth In Lending Credit Policy:

I understand that I am financially responsible for my account regardless of my insurance and for any charges which are either for medical care not covered by my policy or as a result of not following the required procedures of my health plan. All charges are due and payable at the time of service unless otherwise specified by an insurance company that is contracted with us. If payment is not received by 60 days from the time of service, a late charge will be applied to the unpaid balance at an annual rate of 10% [0.83% per month]. Additionally, I accept complete financial responsibility for any ancillary services.

I HAVE RECEIVED THE TRUTH IN LENDING DISCLOSURE STATEMENT PRIOR TO ANY FINANCE CHARGES MADE TO MY ACCOUNT.

I authorize the release of any medical information necessary to process this claim and request payment of medical benefits be made directly to this physician unless payment is made in full at the time of service. There can possibly be a charge for re-processing a claim for insurance purposes. I also understand that it may be necessary for me to bill my own insurance company directly. **It is the patients' sole responsibility to know and understand their insurance policy and benefits. This includes required referrals, copayments, covered lab and x-ray benefits, and prior authorization for procedures.** You must provide us with a current claims address for your insurance company. I am aware that if the above information is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I am also aware if I am to have a referral for services and if one is not obtained by me I will be responsible for all charges related to services provided.

Signature _____ Date _____