

ASSOCIATES IN WOMEN'S CARE

USUAL PROVIDER: _____

PATIENT INFORMATION

Name:	Date of Birth:
Address One:	Social Security #:
Address Two:	PCP:
City:	Former Name:
State: Zip:	Employer:
Home Phone#:	Occupation:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Contact:

MARITAL STATUS: S M D W

RESPONSIBLE PARTY INFORMATION

Name:	Date of Birth:
Address One:	Social Security#:
City:	Home Phone#:
State: Zip:	Employer:
Pharmacy:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Policy/ID#:	Policy/ID#:
Group Number:	Group Number:
Subscriber DOB:	Subscriber DOB:
Subscriber SSN:	Subscriber SSN:
Subscriber Name:	Subscriber Name:

May we call you at work? Y N May we leave message for you at work? Y N

Financial & Information Release

I understand that I am responsible for obtaining a referral or proper authorization from my insurance company if required. I am responsible to know which hospital and/or lab my insurance will reimburse payment to. Specimens such as Pap smear, biopsy tissue samples, genital cultures, or urine will be sent to an outside lab contracted through my insurance company. Therefore an outside charge may be associated with my procedures. I agree that if the insurance company denies benefits for any reason, I will be responsible for the full amount of the services rendered. I also understand and agree to pay a \$30.00 returned check charge. A \$10.00 late fee will be assessed if payment/payment arrangements are not made by due date of bill.

I request that payment of authorized insurance/Medicare benefits be made payable to Associates in Women's Care, P.C. (FEIN84-1278042) on behalf of services furnished to me. In the event that my account is turned over to a collection agency, I agree to pay all reasonable attorney's fees and costs of collection and understand that I am no longer a patient at this office.

I authorize any medical information about me to be released to any or all Health Care Financing Administration, its agents, or my insurance carrier as needed to process and pay my/my dependant claims. I have also been made aware of the privacy policies which are in compliance of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Patients Signature: _____ Date: _____