

ASSOCIATES IN WOMEN'S CARE

USUAL PROVIDER: _____

MARITAL STATUS: S M D W

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

Name:	Date of Birth:
Address One:	Social Security #:
Address Two:	E-Mail Address:
City:	How do you prefer to be contacted? Check below:
State: Zip:	Phone _____ E-Mail _____ or Mail _____
Home Phone#:	Preferred Language (s)
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Contact:

Optional: RACE/ETHNICITY Two-Part Question. Please answer BOTH questions. (Check as many as apply) OR Declined _____ ("x" if you decline to answer)	DEFINITION OF CATEGORY
<p>Are you Hispanic or Latino? Yes ___ No ___</p> <p>___ Yes, Hispanic or Latino</p> <p>What is your race? (<i>regardless of how you answered the first question</i>)</p> <p>___ American Indian or Alaska Native</p> <p>___ Asian</p> <p>___ Black or African American</p> <p>___ Native Hawaiian or Other Pacific Islander</p> <p>___ White or Caucasian</p>	<p>A person of Mexican, Puerto Rican, Cuban, South or Central American, or Other Spanish culture or origin, regardless of race.</p> <p>A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.</p> <p>A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.</p> <p>A person having origins in any of the black racial groups of Africa.</p> <p>A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</p> <p>A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.</p>

RESPONSIBLE PARTY INFORMATION (spouse or parent if under 18)

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:

BY SIGNING BELOW I AM VERIFYING THAT I HAVE READ AND AGREE TO THE GUARANTORS BILLING AGREEMENT ON THE REVERSE SIDE OF THIS FORM.

GUARANTOR
SIGNATURE _____ DATE _____
PRINT NAME _____

Guarantor's Billing Agreement

- 1) I understand that if the insurance claim is denied due to incorrect information that I have provided, I will be billed, and payment in full will be due immediately.
- 2) I hereby request and authorize Associates In Women's Care physicians & personnel to deliver medical care to the patient.
- 3) I verify that I have reviewed the information on the first page and that it is correct.
- 4) If Associates In Women's Care is contracted with the patient's insurance company, I authorize assignment of payment directly to the physician for services provided to the patient. I understand that Associates In Women's Care will file the claim with the patient's insurance company and that I am responsible for following up with the insurance company to insure the patient's claim is paid within 60 days of the date of service.
- 5) I understand that if the patient has a PPO insurance plan, and the insurance has not paid the patient's claim within 60 days of the date of service, charges for that visit will become my responsibility to pay.
- 6) I understand that under the terms of the contract of the insurance company, co-payments must be paid at every visit.
- 7) If the patient has insurance that Associates In Women's are not contracted with, I agree to pay the bill in full at the time services are provided. I understand that Associates In Women's Care will file a claim with the patient's primary insurance company as a courtesy but that is my responsibility to follow up with the patient's insurance company to insure personal reimbursement by them.
- 8) I understand that if I have no insurance coverage, I agree to pay the balance in full at the time services are provided to the patient.
- 9) I understand that medical records are the property of the physicians of Associates In Women's Care; however, the patient is entitled to photocopies, with sufficient advanced notice, upon the patient's written request. I understand that there may be a charge for these photocopies.
- 10) I hereby authorize the release of the patient's medical information to the insurance company concerning any illness and treatment associated with Associates In Women's Care.
- 11) I acknowledge that I can obtain a copy of the Associates In Women's Care Privacy Rights/HIPAA information from the front desk upon my request.
- 12) I understand that a **\$30.00** fee will be charged for all appointments if missed or not canceled at least 24 hours in advance.
- 13) A \$10.00 late fee will be assessed if payment/payment arrangements are not made by due date of bill.
- 14) I understand that if the patient's account becomes past due, Associates In Women's Care will take the necessary steps to collect this debt. If Associates In Women's Care has to refer the patient's account to a collection agency, I agree to pay all of the collection fees. If Associates In Women's Care has to refer the patient's account balance to a lawyer, I agree to pay all legal fees incurred plus all court costs.
- 15) I understand that Associates In Women's Care may dismiss a patient from the practice if the patient has outstanding balance.
- 16) I understand that I am responsible for knowing the benefits of the patient's specific insurance company, and that Associates In Women's Care is not responsible for interpreting these benefits. Associates In Women's Care is also not responsible for how the patient's insurance company(s) processes claims. I further understand that Associates In Women's Care **cannot** serve as an intermediary between the insurance company and the patient in claims processing or claims disputes; and that I must personally resolve these matters with the patient's insurance company.
- 17) I understand that it is the patient's responsibility to inform Associates In Women's Care if the patient chooses not to have their insurance billed at the time of service.
- 18) I understand that Associates In Women's Care will not be responsible for claims sent to the insurance company that identify specific conditions that the patient is wanting to keep private if the patient does not inform Associates In Women's Care prior to checking out at the time of service.
- 19) I understand that if the patient chooses not to bill his/her insurance at the time of service payment is due in full at check out.
- 20) I understand that Associates In Women's Care cannot guaranteed prices prior to treatment, however; prices may be quoted but not guaranteed at the time service

I verify that the information on the reverse side of this form is current and unchanged. If this information is not current I will be billed for any denied claims.