Women's Health Specialists

Name _____ Account # _____
First Middle Last

Home Address _____ Phone Number _____
Street Address City Zip

Date of Birth _____

Social Security # _____

❑ Married ❑ Single ❑ Divorced ❑ Widow ❑ Minor ❑ 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 (PCP) _____

Insurance Info – Primary ❑ HMO Med Group_____ ❑ PPO ❑ POS ❑ 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 ❑ HMO Med Group_____ ❑ PPO ❑ POS ❑ 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:
- ❑ **Patient Only**
- ❑ **Family member or friend** _____
- ❑ **Physician**
- ❑ **Other** _____

Detailed Messages regarding test results can be left on answering machine
- ❑ **Yes** **Phone Number** _____
- ❑ **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.

Signature _____ Date _____