

Bring 2 copies to office

For Internal Use Only
PT ID Number _____
Last Verified _____

Patient Information

Last Name _____ First Name _____ M.I. _____ Maiden or Nickname _____
Street Address _____ Apt. _____ P.O. Box _____
City _____ State _____ Zip _____
Social Security # _____ Birth Date _____ Marital Status Single Married Divorced Widowed
Home Phone # (____) _____ - _____ Work Phone # (____) _____ - _____ Ext. _____ Cell Phone # _____
E-Mail Address _____ May we email you? Yes No

Clinical Research: We do clinical research to advance women's health. May we notify you of upcoming studies? Yes No

May we examine your medical record, and/or billing information to determine your eligibility for a Clinical Study? Yes No

Patient's Employer Information

Employer Name _____ Employer Phone # _____
Employer Address _____ Street _____ City _____ State _____ Zip _____
Occupation: _____ If Student Full time Part time School _____

Insurance Information - Primary / Secondary / Other Do you have health insurance? Yes No

Primary Insurance _____ **Copy of Card?** Yes No
Subscriber _____ Relationship _____

Secondary Insurance _____ **Copy of Card?** Yes No
Subscriber _____ Relationship _____

Spouse's Or Parent's Information (If Patient is covered by Spouse's / Parent's Insurance)

Name _____ Birth Date _____ SS# _____
Employer _____ Employer's Phone # (____) _____
Employer Address _____

Emergency Information: List nearest relative preferably not living with you.

in case of an emergency, we may contact: _____ (____) _____
Telephone No. _____ Relationship to Patient _____

Other

Primary Care Physician: _____ Primary Physician in This Office: _____ Referring Physician: _____

Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Physicians for Women's Health LLC will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law.

I further agree to pay all costs of collection, including attorney's fees, associated with collection of any amount due for services rendered. I will pay interest at the prevailing annual rate for all amounts 30 days past due. I understand that I am financially responsible to the Physicians for Women's Health LLC, its successors and assigns and any individual it may designate for amounts owed by me in accordance with my health benefit coverage.

Signature of Patient or Parent of Minor _____ Date _____

Medicare Authorization for Treatment, Payment & Healthcare Operations, Medicare Recipients Sign both Authorizations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Physicians for Women's Health LLC for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

Patient's Signature _____ Date _____

Notice of Privacy: Received Refused _____

Signature of Patient or Parent of Minor _____ Date _____

May release protected health information to: _____