Patient Information Form

*Please **print** all information in the spaces provided. Be sure to complete and sign the statement on the back of this form.*

Last Name______________________________ First Name______________________________ M.I.________

Home Address____

Home Phone_______________________________ Work Phone_______________________________________

Employer Name and Address____

Social Security Number_____________________________ Date of Birth_______________________ Age________

Male / Female Marital Status **S M W D** Email Address_______________________________

Please bring insurance card and photo ID to your appointment

Primary Insurance

Company Name____ Phone Number_________________

Billing Address____

Name of Insured and Relation to Patient____

Insured's ID Number____________________________ Group Number_________________________________

Secondary Insurance

Company Name and Phone Number____

Billing Address____

Name of Insured and Relation to Patient____

Insured's ID Number____________________________ Group Number__________________________________

Name and phone number of person to contact in case of an emergency ____

I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

Signature of patient or patient's representative ____Date ___________.

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, ________________________________ , hereby authorize **Womens Health Professionals** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **Womens Health Professionals** can refuse to treat me.

I have been informed that **Womens Health Professionals** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying **Womens Health Professionals**, in writing, but if I revoke my consent, such revocation will not affect any actions that **Womens Health Professionals** took before receiving my revocation.

I understand that **Womens Health Professionals** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **Womens Health Professionals** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **Womens Health Professionals** does not have to agree to such restrictions, but that once such restrictions are agreed to, **Womens Health Professionals** must adhere to such restrictions.

Signature of patient or patient's representative ____Date ___________
(Form MUST be completed before signing.)

Printed name of patient or patient's representative __________________________________

Relationship to the patient ___________________________________