Women's Health Care in San Diego, A Medical Corporation

Share/nurse/word/pt info/9-17-13

Patient Information: **Account #** _____

Patient's Name: _____ **Age:** _____ **Birth Date**_____

Maiden Name: _____**Home Phone # ( )** _____

Home Address: _____**Cell Ph. Or Pager # ( )** _____

City: _____ **State:** _____ **Zip Code:** _____**Work # ( )** _____ **Ext.** _____

Mailing Address: (If Different From Above): _____

Social Security #: _____ **Driver's License #:** _____**State:** _____ **Marital Status: S / M / D / W**

If Minor, Name of Parent or Guardian: _____ Phone: ( ) _____

Social Security # of Parent/Guardian: _____ **Drivers License #:** _____ **State** _____

Patient's Employment Information (Or Responsible Party, If Minor):

Name of Employer: _____**Occupation**_____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Spouse Name: _____ **DOB:** _____ **Social Security #:** _____

Employer's Name: _____ **Occupation:** _____ **Phone: ( )** _____

Primary CarePhysician_____**Phone**_____

HOW DID YOU HEAR ABOUT THIS OFFICE? _____

Do you have health insurance: Yes / No If yes, is it an: HMO: _____ **PPO:** _____ **OTHER:** _____

Other health insurance: Yes / No If yes, is it an: HMO: _____ **PPO:** _____ **OTHER:** ____

Health Insurance Contracted Labs: LabCorp: _____ Quest: _____ Sharp: _____ Other: _____
**** Call your Health Insurance Company before appointment to verify contracted lab information. ****

**** Bring ALL Health Insurance Cards on the date of your appointment otherwise payment for services will be required. ****

I verify that the above information has not changed: (Do not sign if you are a new patient)

Patient Signature_____**Date**_____

Patient Signature_____**Date**_____

Patient Signature_____**Date**_____

Women's Health in San Diego, A Medical Corporation

Emergency Contact Information:

Name: _____**Relationship:** _____

Phone: ( ) _____**Address**_____

Would you like an Advance Directive Form? Yes / No

Payment Agreement and Insurance Authorization:

I agree that payment is to be made at the time the service is rendered unless prior arrangements are made. I authorize Women's Health Care to bill my insurance and to receive the payment for Medical benefits directly and to furnish information to the insurance carrier concerning my illness and treatments. Regulations pertaining to medical assignment of benefits apply. I understand that I am responsible for all amounts not covered by my insurance as well as services provided outside of the office (Pap Interpretations, Labs, Ultra Sounds etc.). I further agree that in the event of non-payment, I will bear the cost of collections and court costs and reasonable legal fees, should action be required. I also understand that failure to cancel my appointment(s) or reschedule 24 hours in advance will be subject to a $25 charge. I agree that a photocopy of the authorization shall be valid as an original.

I authorize Women's Health Care in San Diego, A.M.C. to discuss financial matters with _____ _____
(Print Name) **(Relationship)**

Patient Signature: _____ **Date:** _____

Signature of Responsible Party for Payment: _____ **Date:** _____

Acknowledgement of Receipt of Privacy Notice:

(Complete this section below at your appointment time in the office.)
I hereby acknowledge that I have been presented with a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. I understand the contents of the notice, and request the following restriction(s) concerning the use of my personal medical information:

_____

_____

Patient Signature: _____ **Date :** _____
If not signed by patient, please indicate relationship to patient (e.g., Spouse, Parent, Legal Guardian)

Relationship: _____ **Witnessed by:** _____