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 _____ DOB _____ Last Four Digits of SS # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Other Home phone: _____

Work phone: _____ Ext _____ Cell Phone: _____ Primary # to call me: ☐ H ☐ W ☐ C

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 _____ DOB _____ Relationship _____

Secondary Insurance _____ **Copy of Card?** ☐ Yes ☐ No

Subscriber _____ DOB _____ Relationship _____

☐ Spouse's Or ☐ Parent's Information

Name _____ Birth Date _____ Last 4 digits of SS# _____

Employer _____ Employer's Phone # (_____) _____

Employer Address _____

Emergency Information: MUST BE COMPLETED (e.g. nearest relative preferably not living with you)

In case of an emergency / urgent matter, 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 my 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 unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as costs including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Physicians for Women's Health LLC, its successors and assigns or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I understand and acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

_____
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: _____
Name Relationship

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