Women's & Family Care Patient Information Record

Patient Name _____ Date of Birth _____ SS# _____

Address _____ Home Phone # ( ) _____
Street City State Zip
Mobile Telephone # ( ) _____ Preferred Email Address _____

Employer _____ Occupation _____ Work Telephone # ( ) _____

Marital Status: M S D W Mother's Name _____ Father's Name _____

Name of Spouse _____ Spouse's SS# _____ Spouse's Date of Birth _____

Spouse's Occupation _____ Work Telephone # ( ) _____

People with whom you may discuss my medical care: _____

Emergency Contact Name _____ Relationship _____ Phone # _____

Student? Yes FT PT School _____

Primary Care Physician _____ Phone # _____ Today's Date ____/____/____

Preferred Pharmacy: _____ Phone Number ( ) _____

Who May We Thank For Referring You To Our Practice? _____
May we have your permission to call or write and thank them? Y N

Planned Method of Payment: ( ) Insurance/Medicaid/Medicare Name of Insurance Co: _____
Insurance Policy Holder Name: _____ Date of Birth: _____ SS# _____
Relation to Patient: _____
( ) Self Pay ( ) Care Credit Application Completed ( ) Cash ( ) Credit Card ( ) Check

Please call my ( ) Home #, ( ) Mobile #, ( ) Work# with questions/lab results.
Please do not call me with lab results but email them understanding the account used is not encrypted. ( )

Please Note: This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.
Payment for office charges is expected at the time services are rendered.

I currently have Advance Directives in place and will provide a copy as soon as possible. ( )

Insurance Authorization and Assignment

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED and co-pays and outstanding balances are due at the beginning of each visit.. I understand that cash and credit cards are the preferred method of payment. Checks will be accepted on a case by case basis. I also understand that if I am a Medicare Beneficiary and Medicare does not cover the services I receive, I will be responsible for the charges. I authorize payment by my insurance company directly to Comprehensive Women's Care, Inc. D/B/A Women's & Family Care.

I have received Comprehensive Women's Care, Inc. D/B/A Women's & Family Care, New Patient Packet, Advanced Directive Information, Patient Rights and Responsibilities, Financial Policies and Notice of Privacy and understand the policies and procedures as well as my rights in general and specifically related to my finances and personal health information. I authorize Comprehensive Women's Care, Inc. to release necessary personal health information to secure payment from third party payors.

Signed _____ Date _____ RELATIONSHIP TO PATIENT _____

Medigap Lifetime Certificate

I request that payment of authorized Medicare/Medigap benefits be made to either me or on my behalf to Comprehensive Women's Care, Inc., D/B/A Women's & Family Care, any services furnished my by these health care providers. I authorize any holder of my personal health information to release to the Health Financing Administration and its agents necessary personal health information necessary to determine these benefits of the benefits payable for related services. I understand that there are health care services that may not be paid for by Medicare. If Medicare does not cover these services, I understand that I will be responsible for paying for them.

Signature of Beneficiary _____ Medicare/Medigap # _____

Date Signed _____ Medigap Insurer _____