# *Women's Healthcare Affiliates, P.A.*

***Welcome to Women's Healthcare Affiliates, P.A.. We are committed to providing our patients with the highest quality of care & service. Thank you for selecting Women's Healthcare Affiliates, P.A. for your total healthcare needs.***

***Appointment Date:*** ___________ ***Appointment Time:*** ___________ ***am/pm*** ***Physician:*** ______________________________

***Referred By:*** ________________ ***Primary Care Physician:*** _____________________ ***E-Mail Address:*** ______________________________

## *Patient Information*

| | | | | | |
|---|---|---|---|---|---|
| Patient Name *(Last, First M.I.)* | | | Home Telephone # ( ) | | Work Telephone # ( ) |
| Street Address | | | Date of Birth / / | | Social Security # - - |
| City | State | Zip | Sex ☐M ☐F | Employed ☐Y ☐N | Student ☐Full-time ☐Part-time |
| Name of Employer / School | | | Occupation | Marital Status ☐S ☐M ☐W ☐D | Race |
| Employer's Street Address | | | City | State | Zip |
| Name of Spouse (if applicable) | Spouse's Employer | | Spouse's Telephone # ( ) | | Other Telephone # ( ) |
| Emergency Contact (Other than Spouse & Guarantor) | | | Relationship to patient | Emergency Telephone # ( ) | |
| Name of Guarantor (Responsible Party) | | | Relationship to patient | Guarantor's Telephone # ( ) | |
| Guarantor's Street Address | | | City | State | Zip |

***** Please complete form in its entirety*****

## *Insurance Information*

| | | | | |
|---|---|---|---|---|
| Insurance Company *(Primary)* | | | Name of Insured | Insurance Company's Telephone # ( ) |
| Insurance Company's Address | | | Policy ID # / S.S.# | Policy Group # |
| City | State | Zip | Relationship to Patient | Insured's Date of Birth |
| Insured's Employer | | | Employer's Telephone # ( ) | |
| Insurance Company *(Secondary)* | | | Name of Insured | Insurance Company's Telephone # |
| Insurance Company's Address | | | Policy ID # / S.S.# | Policy Group # |
| City | State | Zip | Relationship to Patient | Insured's Date of Birth |
| Insured's Employer | | | Employer's Telephone # ( ) | |

*Please note: In order for our office to receive reimbursement from your insurance company according to the contractual terms set by your insurance plan, we request that you inform our office of any insurance changes immediately prior to or upon check-in for your visit and/or services. Failure to notify our office in a timely manner of the appropriate changes will result in the patient and/or guarantor assuming full responsibility of the balance.*

# *Women's Healthcare Affiliates, P.A.*

Patient Name: ____________________ Date of Birth: ____________

1. I authorize my insurance carrier to release information regarding my coverage to Women's Healthcare Affiliates, P.A. *(WHA)*. I also authorize agents of any hospital, treatment center or previous physicians to furnish *WHA* copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to the review of my records for purposes of internal audits, research and quality assurance reviews within *WHA*.

2. My right to payment for all procedures, tests, supplies and nursing/physician services including major medical benefits are hereby assigned to *WHA*. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to *WHA*.

3. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree that in the event that I do not have insurance or any other third party reimbursement program, that I am fully responsible for payment of services. I also agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

4. I hereby am voluntarily seeking health care and give authorization and consent of any necessary medical treatment that is required while under the care of one or more physicians within *WHA*. I understand that specific procedures, laboratory tests and any other ancillary service may be ordered and performed in an effort of properly diagnosing and treating a medical condition and/or part of preventative care. I also understand that these services may or may not be covered under my health insurance carrier, therefore, would be my responsibility. I have the right to refuse specific treatments or procedures. I acknowledge that this agreement of "Medical Consent for Treatment" can be revoked by me at any time by written notification and is valid until revoked.

**THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.**

I have read and received a copy of the above statements and accept the terms. A duplicate of this statement is considered the same as original.

______________________________ ______________________

Patient Signature Today's Date/Time AM or PM (*circle)*

______________________________ ______________________

Responsible Party Signature Relationship to patient Today's Date/Time AM or PM (*circle*)

PHYSICIAN: ______________________

ACCT NBR: __________ LOC: __________

FOR OFFICE USE ONLY

EMPLOYEE INITIALS

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