CLEAR FORM

Doctor: Choose Your Physician

Account #

PLEASE PRINT

PATIENT INFORMATION/YEARLY UPDATE

DATE: _____

PATIENT'S NAME	MARITAL STATUS S ☐ M ☐ W ☐ D ☐ SEP ☐	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
STREET ADDRESS PERMANENT TEMPORARY	CITY AND STATE		ZIP CODE	HOME PHONE NO.
PATIENT'S CELL NUMBER	PATIENTS EMAIL ADDRESS			
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF A STUDENT)	HOW LONG EMPLOYED		BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE
PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN SPOUSE)	ADDRESS			PHONE NO.
SPOUSE OR PARENT'S NAME	DATE OF BIRTH	SPOUSE OR PARENT'S SS NO.		
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF A STUDENT)	HOW LONG EMPLOYED		BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICE.

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	INSURED'S NAME	EFFECTIVE DATE
INSURED'S EMPLOYER	INSURED'S ID#	PATIENT'S RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD

SECONDARY INSURANCE COMPANY	INSURED'S NAME	EFFECTIVE DATE
INSURED'S EMPLOYER	INSURED'S ID#	PATIENT'S RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD

FAMILY DOCTOR	ADDRESS	PHONE	REFERRED BY

*** I have received a notice of the Privacy Practices from Women's Health Care, P.C.**

Date _____ Patient _____

Date _____ Spouse/Parent _____

(OVER)

Form #72

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT AUTHORIZATION

I HEREBY AUTHORIZE THE ABOVE PHYSICIAN(S) TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED BY HIM AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE.

_____ _____

DATE PATIENT (PARENT OR GUARDIAN, IF MINOR)

I HEREBY AUTHORIZE AND DIRECT MY INSURER TO ISSUE PAYMENT CHECK(S) FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE ABOVE NAMED PHYSICIAN(S) TO BE MADE DIRECTLY TO HIM. REGARDLESS OF MY INSURANCE BENEFITS, IF ANY, I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED. I AGREE TO PAY ALL ATTORNEY FEES AND COURT COSTS INCURRED IN COLLECTING ANY UNPAID BALANCES FOR SERVICES RENDERED.

_____ _____

DATE RESPONSIBLE PERSON, POLICY OWNER, INSURED

STATEMENT TO PERMIT PAYMENT OF BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE MY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THE PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES OR ORGANIZATION FURNISHING THE SERVICE OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE FOR PAYMENT TO ME. I REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM BE MADE EITHER TO ME OR TO THE ABOVE NAMED PHYSICIAN(S).

_____ _____

DATE SIGNATURE