Doctors of Women

Patient Name (First, Last Middle)____**Date of Birth**_________________

SSN:____________________________ **Gender:**___________________________ **Marital Status:**_______________

Primary Care Practice/Physician:_________________________________ **PCP Phone:** ________________________

Patient Representative/
Person completing form If Not Patient:____**Relation:**_________________

Mailing Address: ____**Apt #:**___________

City: ____ **State:** _____________ **ZIP:**_______________________

Home Phone#: ___________________________ **Cell#:**__________________________**Work#:**___________________

Email Address: ____

Activate Our office Patient Portal Account ____**Yes** ____**No**
View your visit information, schedule appointments and more on our Patient Portal!

Ethnicity:_______________________________
Race:___________________________________ **Preferred Language:** ____________________________

*********Information collected for census purposes********

***Emergency Contact:**___________________________ **Relationship to patient:** _________________________	***Emergency Contact Phone:**________________________

Preferred Pharmacy: ____

Address/Cross Streets:____
Phone:___________________________

Responsible Financial Party

Name (First, Middle, Last)____________________________________**Date of Birth**_________________

Address: ___________________________________ **Social security #** _____________________**Phone** ____________

INSURANCE and SUBSCRIBER INFORMATION

No need to complete this section if providing an insurance card

Primary Insurance	Secondary Insurance
Insurance Company:_______________________________	Insurance Company:_______________________________
Name of Insured:__________________________________	Name of Insured:__________________________________
Relation to Insured:_______________SSN:____________	Relation to Insured:_______________SSN:____________
Address:____	Address:____
City/State/Zip____________________________________ _	City/State/Zip____________________________________ _
Policy #____	Policy #____
Group #____	Group #____

I authorize release of my personal information including medical treatment, scheduling and billing information to the individuals listed below.

Name	Relationship

Signature of Patient/Patient Representative:____**Date:**____________

CONSENT FOR MEDICAL TREATMENT

I, the patient or the authorized representative of the patient, hereby consent to any examination, evaluation and treatment provided for any illness, injury, or other health concern affecting me at any time I present at Doctors of Women for medical care. These services may include but are not limited to: laboratory procedures, x-ray examinations, review of external pharmacy information and medical and/or surgical treatment or procedures.

FINANCIAL POLICY

1. All patients must provide accurate and complete personal and insurance information prior to being seen by the physician, physician assistant, nurse practitioner or other medical care provider/practitioner.
2. Payment is required at the time of service. Doctors of Women (DOW) accepts payment by cash, check and credit/debit card.
3. Doctors of Women will gladly file a claim with your insurance company; however, it is your responsibility to comply with all pre-determination, pre-authorization and/ or notification requirements as may be required by your insurance plan. While many of the services provided by DOW may be covered benefits of your insurance plan, how these benefits are paid by your insurance provider and/or whether or not certain services are considered to be non-covered services is determined strictly by your insurance provider and not by our office. It is your personal responsibility to understand the limitations and exclusions of your insurance plan, as well as to understand your co-pays, deductibles, in-network and out of network coverage including any and all applicable limitations, inclusions and/or exclusions.
4. Doctors of Women requires that the guarantor agree to be personally liable for all balances due or that may become due related to today's visit.
5. The fees for our services are reasonable and customary fees for this region and specialty. If the patient's insurance company reimburses at a different rate than what is billed by DOW, the patient may be responsible for any balance remaining.
6. We may charge reasonable fees for services related to your account including, but not limited to, returned check fees, interest on unpaid accounts, and medical record copies.
7. Should it be necessary to forward an account balance to a collection agency, the guarantor agrees to assume financial responsibility for reasonable collection costs.
8. Doctors of Women may disclose all or part of a patient's medical or financial records (including information related to alcohol and drug abuse, mental health diagnosis and treatment, HIV related or other communicable disease related information) to third parties to obtain payment for services provided.
9. The patient's personal information will be updated at least one time per year to verify the information on file is accurate. It is the responsibility of the patient to notify our office of any changes of the personal and/or insurance information provided on this form.
10. Federal laws require that DOW submit every claim to an insurance company accurately and report the exact services performed and the exact reason for performing them. It is insurance fraud to change this information in order to try to obtain payment on a claim from an insurance company.

I agree that in the event my insurance provider does not pay for some/all of the charges associated with and incurred for today's visit, I will pay any remaining balance due and that balance will be my personal financial responsibility. I understand that this only applies to Doctors of Women. procedures and charges and that this excludes any and all charges incurred from third party entities as a result of laboratory testing, durable medical equipment, etc. I understand that this Medical Treatment and Financial Agreement is and will be valid for any and all services provided by Doctors of Women effective from the date this Medical Treatment and Financial Agreement is signed by me and does not expire unless and until I inform our office directly that I no longer wish to have this Medical Treatment and Financial Agreement in effect.

I have been given the opportunity to read the office's Notice of Privacy Practices and have had any questions addressed concerning that policy.

Signature of Patient/Patient Representative:____Date:____________