

PATIENT INFORMATION

LAST NAME _____ FIRST _____ MI _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

MARITAL STATUS _____ ETHNICITY _____

EMPLOYER _____ OCCUPATION _____

HOW DID YOU FIND US? INSURANCE BOOK CURRENT PATIENT PHONEBOOK FRIEND

REFERRING DOCTOR _____

DOCTOR TO BE SEEN _____

INSURANCE INFORMATION

INSURANCE COMPANY _____

POLICY HOLDER (IF DIFFERENT THAN ABOVE) _____ RELATIONSHIP _____

ADDRESS _____ PHONE NUMBER _____

DATE OF BIRTH _____ SOCIAL SECURITY _____

EMPLOYER _____

EMERGENCY INFORMATION

PERSON TO CONTACT _____ RELATIONSHIP _____

ADDRESS _____ PHONE NUMBER _____

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our billing manager.

I hereby authorize Crosswoods Women's Health to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician all payments for medical and surgical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

DATE _____ SIGNATURE _____

Disclosure / Agreement

Date: _____

Patient Name: _____

Reason for today's visit

Per insurance guidelines, if your appointment is for a Routine Preventive Exam and you wish to discuss a problem, you may be billed 2 charges for the visit. Your insurance policy will dictate how the claim is processed.

Routine Preventive Exam (I have no medical complaint or significant problem/abnormality that I am aware of)

I have a problem/complaint that I wish to have evaluated/treated by the doctor.

My chief complaint is: _____

My insurance plan covers Preventive Medical Services.

My insurance plan does not cover Preventive Medical Services.

I do not know if my insurance plan covers Preventive Medical Services.

Pregnancy

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf, however, if my insurance company refuses to pay, for whatever reason (e.g., non-covered services, does not pay for preventive medicine visits, my failure to secure a referral from my primary care physician), I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis code solely for the purpose of securing reimbursement from any insurance carrier is inappropriate and may result in a fraudulent act(s).

In the event I do not pay for these or any other services provided me when due, I agree to pay all cost of collection, including reasonable attorney fees, whether or not a lawsuit is commenced as part of the collection process.

By: _____
Patient (or responsible party if minor)

Witness: _____

This disclosure/agreement form is provided with the understanding that the publisher is not engaged in rendering legal or accounting advice.