

WOMEN'S HEALTH ASSOCIATES

Patient's Name: _____ Date of Birth: _____ Age: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

S.S. No.: _____ Driver's Lic #: _____ Marital Status: Single () Married ()

Primary Care Physician: _____ Address: _____ Phone: _____

Email Address: _____

Patient's Employer: _____ Address: _____

Employment Status: Full Time () Part Time () Unemployed () Retired () Disabled ()

Student Status: Full Time () Part Time () Nonstudent ()

Please List Information for the person who carries the Insurance

Primary Insurance: _____ Secondary Insurance: _____

If insurance is filed under spouse or parent, we must have Date of Birth and Social Security Number.

Name: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ S.S. No.: _____

Work Phone: () _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

NOTIFY IN AN EMERGENCY, NOT AT SAME ADDRESS: Name: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Please check method of payment: () Cash () Check () Credit Card () Other: _____

INSURANCE: Please allow us to make a copy of your insurance card(s) and photo I.D.

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to Women's Health Partners of East Tennessee, dba Women's Health Associates all charges for such services and incidentals incurred. Should the account be referred for collection, I shall pay all collection costs of no less than 30% to the collection agency, court costs and reasonable attorney fees. Even though insurance may be filed, I understand that all bills are payable upon receipt and that I and not the insurance company, am responsible for the payment of all services.

Initial: _____

Responsibility for Co-pay Amounts: I agree to be fully responsible for paying co-pays of set amounts at the time of provider visit. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received once insurance is paid will be due upon receipt.

Initial: _____

Assumption of Referrals: I understand that if I have insurance coverage, which requires a referral from a Primary Care Physician, it must be received in order to receive the maximum benefits from the insurance company. I further understand that it is my responsibility to obtain a hardcopy referral from my Primary Care Physician. I have been given the opportunity by the above said provider to obtain a referral or reschedule my appointment. I understand that if I refuse that I am taking full responsibility for payment.

Initial: _____

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of a third party or organization, and so forth, payable to or for the above said patient until account is paid in full.

Signature: _____ **Date:** _____