

PLEASE PRINT ALL INFORMATION

THIS FORM MUST BE FILLED OUT COMPLETELY OR INSURANCE WILL NOT BE BILLED

PATIENT INFORMATION

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
NUMBER STREET APT # CITY STATE ZIP

HOME PHONE (____) _____ CELL PHONE (____) _____

EMPLOYER _____ WORK PHONE (____) _____

SOCIAL SECURITY NUMBER _____ MARITAL STATUS _____

RACE _____ ETHNICITY _____

BIRTH DATE ____/____/____ AGE ____ E-Mail _____

IF PATIENT IS A MINOR WHO IS RESPONSIBLE FOR CHARGES?

NAME ADDRESS PHONE

SOCIAL SECURITY NUMBER DATE OF BIRTH RELATIONSHIP TO PATIENT

EMERGENCY CONTACT _____ (____)
NAME RELATIONSHIP PHONE

WHO MAY WE RELEASE INFORMATION TO?

NAME RELATIONSHIP DATE OF BIRTH

MEDICAL INSURANCE INFORMATION

MUST PRESENT INSURANCE CARD AT EACH VISIT

If you do not have current insurance card you will be responsible for paying all charges at time of service.

PRIMARY INSURANCE

INSURANCE COMPANY NAME ADDRESS

IDENTIFICATION NUMBER GROUP NUMBER EFFECTIVE DATE

SUBSCRIBER NAME ADDRESS DATE OF BIRTH

SUBSCRIBER SSN RELATIONSHIP TO PATIENT EMPLOYER EMPLOYER PHONE

SECONDARY INSURANCE

| | | | |
|------------------------|-------------------------|----------------|----------------|
| INSURANCE COMPANY NAME | | ADDRESS | |
| IDENTIFICATION NUMBER | GROUP NUMBER | EFFECTIVE DATE | |
| SUBSCRIBER NAME | | ADDRESS | DATE OF BIRTH |
| SUBSCRIBER SSN | RELATIONSHIP TO PATIENT | EMPLOYER | EMPLOYER PHONE |

TERTIARY INSURANCE

| | | | |
|------------------------|-------------------------|----------------|----------------|
| INSURANCE COMPANY NAME | | ADDRESS | |
| IDENTIFICATION NUMBER | GROUP NUMBER | EFFECTIVE DATE | |
| SUBSCRIBER NAME | | ADDRESS | DATE OF BIRTH |
| SUBSCRIBER SSN | RELATIONSHIP TO PATIENT | EMPLOYER | EMPLOYER PHONE |

AUTHORIZATION: I hereby assign payment of any and all benefits to be made directly to **WHP (WOMEN'S HEALTH PARTNERS AKA Dr. Carolyn Hixson)** and authorize the release of any information necessary to process claims. I understand that I am responsible for any and all charges not covered by insurance. **I have been made aware that missed appointments may result in a charge of half the fee for that particular service**, this may be charged to me and that my insurance company will not pay for this charge. **Co-pays not paid at the time of service are subject to a processing fee.** Accounts sent to the collection agency are subject to fees as stated in the Financial Policy.

| | |
|---|------|
| PATIENT SIGNATURE | DATE |
| GUARANTOR SIGNATURE IF PATIENT IS A MINOR | DATE |

PHARMACY AUTHORIZATION

I authorize my pharmacy _____,
Pharmacy Name Pharmacy Address

to provide my medication list to **WOMEN'S HEALTH PARTNERS, LLC., DR. CAROLYN HIXSON.**

| | |
|---|---------------|
| _____ Patient Signature or Authorized Representative | _____ Date |
|---|---------------|