# *PARTNERSHIP FOR WOMEN'S HEALTH*

| **PATIENT INFORMATION:** | | | | **CHART #** |
|---|---|---|---|---|
| PATIENT NAME: First Last | DATE OF BIRTH | MARITAL STATUS | HOME PHONE | |
| OCCUPATION | SOCIAL SECURITY NO. | DRIVERS LICENSE | CELL PHONE | |
| HOME ADDRESS | CITY | STATE | ZIP CODE | |
| CITY | STATE / ZIP CODE | EMAIL ADDRESS | | |
| EMPLOYER | EMPLOYER ADDRESS | WORK PHONE | | |
| SPOUSE (OR PARENT/GUARDIAN) | SPOUSE (OR PARENT) OCCUPATION | SPOUSE (OR PARENT) CELL PHONE | | |
| SPOUSE (OR PARENT) EMPLOYER | SPOUSE (OR PARENT) EMPLOYER ADDRESS | SPOUSE (OR PARENT) WORK PHONE | | |
| PRIMARY CARE PHYSICIAN | PHYSICIAN ADDRESS | PHYSICIAN TELEPHONE | | |

**BILLING AND INSURANCE INFORMATION**

| | | | |
|---|---|---|---|
| PRIMARY INSURANCE | INSURANCE COMPANY NAME | ID OR POLICY NUMBER | GROUP/CODE |
| | INSURANCE COMPANY ADDRESS | POLICYHOLDER'S SOCIAL SECURITY | DATE EFFECTIVE |
| | POLICYHOLDER'S NAME | HOME PHONE | RELATIONSHIP TO PATIENT |
| | POLICYHOLDER'S ADDRESS | WORK PHONE | POLICYHOLDER'S DATE OF BIRTH |
| SECONDARY INSURANCE | INSURANCE COMPANY NAME | ID OR POLICY NUMBER | GROUP/CODE |
| | INSURANCE COMPANY ADDRESS | POLICYHOLDER'S SOCIAL SECURITY | DATE EFFECTIVE |
| | POLICYHOLDER'S NAME | HOME PHONE | POLICYHOLDER'S NAME |
| | POLICYHOLDER'S ADDRESS | WORK PHONE | POLICYHOLDER'S DATE OF BIRTH |

**HOW DID YOU HEAR ABOUT US?**

☐Physician: Referred by _____ ☐Website

☐Patient/Friend: Referred by _____ ☐Insurance Company

☐Other_____

**BILLING TERMS AND CONDITIONS AND PATIENT AUTHORIZATION**

Payment is required at the time services are rendered and is the responsibility of the patient, parent, or guardian. Unless other arrangements are made, unpaid balances are due within 30 days of receipt of the invoice. Accounts with balances open for more than 90 days may be charged interest on the unpaid balance at a rate of 12% per annum. If it is necessary to refer the account to our collection attorneys, the patient agrees to pay the cost of collection including attorney's fees of 25%. **A $35 fee may be accessed for not keeping an appointment or for cancellation with less than 24 hour notice.**

I, the patient named above, hereby authorize the Partnership for Women's Health to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company, as referenced above, be made directly to the above-named provider. I understand that I am financially responsible for all charges whether or not I am covered by insurance.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the insurance company named above. I permit a copy of this authorization to be used in place of the original.

I authorize the provider or designated representative to contact me by telephone about appointments, billing, and medical care. As the patient or parent/guardian, I agree to the above terms and conditions.

_____ _____

Signature of Patient or Parent/Guardian Date: