PATIENT INFORMATION **___UPDATED INFORMATION**

Pt.'s Name____DOB:___________________SSN:_________________

Address: ____City:___________________State:______Zip:_________

Home: ____________________________Celll:____________________________Work:________________________

Marital Status: M / D / S / W Ethnicity: _______________________ Occupation: _____________________________

Emergency Contact: _______________________Relationship:________________Phone#:______________________

Primary Care Physician: ____Phone#:_____________________

IF THE PATIENT IS A MINOR

Name of Parent or Legal Guardian: ____

Address: ____City:_____________State:__________Zip:_______

Contact #:____

Insurance # 1:_________________________ID#:________________________________Group#:________________

Subscriber's Name: __________________________________DOB:________________SSN:____________________

Insurance # 2:_________________________ID#:________________________________Group#:________________

Subscriber's Name: __________________________________DOB:________________SSN:____________________

Office use only

Eligibility date: ____________________Copay: $_____________Deductible: $_______________Met: $__________

Secondary date: ____________________Copay: $_____________Deductible: $_______________Met: $__________

*Please make sure the receptionist has your **current** insurance information such as insurance card, ID numbers, name of primary insured etc. Thank you.

Authorization: I hereby authorize physician to furnish information to insurance carriers concerning any illness/accident. I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

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Signature Date

This office applies $25 charge to your account for NSF charges and missed appointments that are not cancelled 24 hours prior to the appointment time.

Authorization for Use and Disclosure of Protected Health Information

I____, hereby authorize, New Start Women's Care to use and/or disclose the following protected health information (PHI) to:

__________________________________Relationship:___________________________________

__________________________________Relationship:___________________________________

__________________________________Relationship:___________________________________

I authorize New Start Women's Care to leave a message regarding my results on the phone number provided.

YES / NO (Circle one) Phone: (_________) _____________________________________

This PHI is being use or disclosed for the following purposes:

<u>Providing appointment reminders</u>

<u>Describing or recommending treatment alternatives</u>

<u>Providing health information about health-related benefits and services that may be of interest to the individual soliciting funds to benefit the covered entity</u>

I understand that I have the right to revoke this authorization at any time by submitting a written request and that a revocation is not effective prior to the revocation date. Furthermore, I understand that the information used for disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy regulations.

I also understand that I have the right to refuse to sign this authorization and my treatment or eligibility for benefits will not be conditioned upon this authorization.

The use or disclosure requested this authorization will result in direct or indirect compensation to New Start Women's Care from third party.

This authorization will remain in effect until further notice from patient or legal guardian of patient.

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Signature of Patient or Representative Guardian Date

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Printed Name of Patient or Representative/Guardian Date