Jackson Healthcare for Women

Date: **Provider:** **Chart #:**

PATIENT INFORMATION			
Patient #:	Date of Birth:	Age:	Race:
Last Name:		SS #:	Marital Status:
First Name: Initial:		Primary Contact Phone:	
Address:		Work Phone:	
City, State, Zip:		Cell Phone:	
Employer:		Occupation:	
Referred By:		Email address:	
Emergency Contact: (Other than spouse)		ER Contact Phone #:	
Spouse Name:		Spouse DOB:	Spouse SS#:
Spouse Home #:		Spouse Employer:	
Spouse Cell #:		Spouse Work #	

Primary Insurance		Insured Policy ID:	
Address:		Group Number:	Group Name:
City, State, Zip:		Policy/Subscriber:	
Plan Phone:		Date of Birth:	
Second Insurance		Insured Policy ID:	
Address:		Group Number:	Group Name:
City, State, Zip:		Date of Birth:	
Plan Phone:		Policy Subscriber:	
IF MINOR, PLEASE COMPLETE		**Signature:**	
Parent/Guardian:		Relationship:	
Address:		Phone #:	
City/State/Zip:			
RESPONSIBLE PARTY (Other than Patient)		**Signature:**	
Name:		Relationship:	
Address:		Home Phone #:	
City/State/Zip:		Work Phone #	
		Cell #	

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

I authorize the release of medical information necessary to process a claim on any insurance policy listed above. I hereby assign to and authorize payment directly to this Clinic, of all benefits payable under such insurance policy. I realize that the insurance benefits may not pay all of the bill, and I agree to the difference or the entire bill if necessary. In the event my account is given to an attorney for collection, I shall pay the reasonable attorney's fee, all court costs, and any expense incurred. Should a judgment be rendered against me, I agree to pay all costs of collection, including the reasonable attorney's fee, all court costs and expenses incurred.

Date: _____ SIGNATURE OF PATIENT: _____

THIS OFFICE WILL ASSIST THE PATIENT TO COMPLETE THE NECESSARY INSURANCE FORMS. BUT IT SHOULD BE UNDERSTOOD THAT THE PATIENT ACCEPTS PERSONAL RESPONSIBILITY FOR THE PAYMENT OF CHARGES FOR SERVICES RENDERED.

Many tests performed in our office require specimens to be sent to an outside (reference) lab for further assessment. These tests include certain PAP smears, biopsies (e.g. cervical biopsies, endometrial biopsies), HPV (human papilloma virus) testing, and special blood tests. Your insurance may or may not pay for these tests. Your signature below reflects your understanding that if your insurance does not pay in full, you will be billed for the balance from our office and/or the outside (reference) lab(s) that performs these additional tests. Also, by signing below you are authorizing Jackson Healthcare for Women, P.A. to release your medical and demographic information to these outside (reference) labs. This information will be used by these entities to file your insurance for the services they perform.

Date:_____ SIGNATURE: _____

I have received a copy of Jackson Healthcare for Women P.A. Notice of Privacy Practices.

Date:_____ SIGNATURE: _____