WOMEN'S HEALTH of Central Massachusetts

Women's Health of Central MA - Women's Health Connecticut www.whcma.com www.womenshealthct.com

Patient Information

Last Name: **First Name**: **M.I.**: **Maiden or Nickname**_____

Street Address: **Apt**:_____ **PO Box**_____ **City**:

State: **DOB**: **Last Four Digits of SS#** **Preferred Language**:

Marital Status: **Ethnicity**:

Race:

Home phone: **Work phone**: **Ext**____ **Cell phone**:

Primary # to call me: ☐ H ☐ W ☐ C

Contact Preference: ☐ Home Phone ☐ Cell ☐ Mail ☐ Portal

Email address May we email you for other than medical reasons? ☐ Yes ☐ No

In case of Emergency/Urgent matter, we may contact: MUST BE COMPLETED (e.g. nearest relative preferably not living with you)

Name: **Relationship**: **Phone #**:

Insurance Information **Do you have health insurance?** ☐ **Yes** ☐ **No**

Primary Insurance: **Insurance Address**:

Policy #: **Group #**_____ **Copay**_____

Policy Holder: **DOB**: **Relationship**_____

Secondary Insurance: **Insurance Address**:

Policy #: **Group #**_____ **Copay**_____

Policy Holder (GUARANTOR): **DOB**: **Relationship**_____

Complete for Policy Holder if other than self: **Last Four Digits of SS#**_____ **Employer**_____

Employer Phone #_____ **Employer Address**_____

Other Information

May we have your consent to obtain the list of all your current medications from pharmacy networks? ☐ Yes ☐ No

Employer: **Employer Address**:

Occupation: **If Student Full time Part time School Name**_____

Primary Care Physician_____ **Referring Physician**_____

Primary Physician in This Office_____ **Pharmacy Name & Phone**.

Clinical Research: We do clinical research to advance women's health. May we notify you of upcoming studies? ☐ **Yes** ☐ **No**

May we examine your medical record, and/or billing information to determine your eligibility for a Clinical Study? ☐ Yes ☐ No

Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Physicians for Women's Health LLC will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as costs including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I understand an acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

Patient's Signature Date

Medicare Authorization for Treatment, Payment & Healthcare Operations, Medicare Recipients Sign both Authorizations.

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized medicare benefits be made either to me or on my behalf to Physicians for Women's Health LLC for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

Patient's Signature Date

Notice of Privacy: ☐ Received ☐ Refused

Signature of Patient or Parent of Minor Date

May release protected health information to:

Name Relationship