PATIENT INFORMATION, DISCLOSURE STATEMENT, & PAYMENT AGREEMENT

ALL PATIENTS ARE RESPONSIBLE TO SOUTHWEST WOMENS HEALTH ASSOCIATES FOR
CHARGES AS BILLED WITH PAYMENT IN FULL AT THE TIME OF SERVICE

PATIENT - LAST NAME (MR. MRS. MS. MISS)		FIRST NAME		MIDDLE NAME
PATIENT MAILING ADDRESS	APT. NO.	CITY	STATE	ZIP
E-MAIL ADDRESS		HOME PHONE ( )		CELL PHONE ( )
PATIENT STATUS ❑ MAR ❑ SING ❑ OTHER	DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐
PATIENT'S EMPLOYER				WORK PHONE / EXTENSION ( )
(FOR PATIENTS UNDER 18) RESPONSIBLE PARTY		PHONE ( )		SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐
IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY? NAME		RELATIONSHIP		PHONE ( )
RELATIVE NOT LIVING WITH YOU - NAME		RELATIONSHIP		PHONE ( )
NAME OF INSURANCE	SUBSCIBER			SUBSCRIBERS D.O.B.
ETHNICITY -	❑ HISPANIC	❑ NON-HISPANIC	❑ REFUSED	
RACE -	❑ REFUSED	❑ UNKNOWN	LANGUAGE PREFERENCE	❑ REFUSED

DISCLOSURE STATEMENT: YOU ARE RESPONSIBLE FOR PAYMENT OF ALL CHARGES INCLUDING REASONABLE ATTORNEYS FEES, ALL COSTS OF COLLECTION AND RETURN CHECK CHARGES. ALL ACCOUNTS ARE DUE AND PAYABLE IN FULL WHEN THE SERVICE IS RENDERED. IF EXTENDED TERMS ARE DESIRED ON LARGER BALANCES, OUR CREDIT MANAGER WILL BE DELIGHTED TO DISCUSS THE MATTER OF A PAYMENT SCHEDULE THAT WILL BEST SUIT YOU. IF YOU HAVE HEALTH INSURANCE THAT WILL PAY FOR SERVICES RENDERED, PLEASE NOTE THAT YOU HAVE AN ADDITIONAL COPY FOR YOUR INSURANCE BILLING. YOU ARE RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT REGARDLESS OF ANY INSURANCE COVERAGE YOU MAY HAVE.

I HEREBY AUTHORIZE SOUTHWEST WOMENS HEALTH ASSOCIATES TO RECEIVE PAYMENT FOR SERVICES RENDERED. I ALSO AUTHORIZE SOUTHWEST WOMENS HEALTH ASSOCIATES TO FURNISH INFORMATION TO ANY PAYER FOR THE PURPOSE OF CLAIMS PROCESSING. I HEREBY ACKNOWLEDGE RECEIPT OF THIS FORM WITH FULL DISCLOSURE STATEMENT ABOVE AND I AGREE TO BE BOUND BY ITS TERMS AND CONDITIONS.

DATE ______________________ SIGNATURE OF PATIENT OR LEGAL GUARDIAN ______________________