SOUTHWEST WOMENS HEALTH ASSOCIATES

PATIENT INFORMATION, DISCLOSURE STATEMENT, & PAYMENT AGREEMENT

PATEINT - LAST NAME	**FIRST NAME**	**MIDDLE NAME**		**PREFERRED PRONOUN**
PATEINT MAILING ADDRESS	**APT. NO**	**CITY**	**STATE**	**ZIP**
E-MAIL ADDRESS	**HOME PHONE** ( )		**CELL PHONE** ( )	
PATIENT STATUS ☐ **MAR** ☐ **SINGLE** ☐ **OTHER**	**DATE OF BIRTH**	**AGE**	**GENDER**	**SOCIAL SECURITY NUMBER**
PATIENT'S EMPLOYER			**WORK PHONE / EXTENSION** ( )	
(FOR PATIENT'S UNDER 18) RESPONSIBLE PARTY		**PHONE**		
IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY?	**NAME**	**RELATIONSHIP**	**PHONE** ( )	
RELATIVIE NOT LIVING WITH YOU – NAME		**RELATIONSHIP**	**PHONE** ( )	
NAME OF INSURANCE	**SUBSCRIBER**		**SUBSCRIBERS D.O.B.**	
PREFERRED PHARMACY				

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 NEEDED ON LARGER BALANCES, OUR OFFICE MANAGER WILL DISCUSS A PAYMENT SCHEDULE. IF YOU HAVE HEALTH INSURANCE, THE INSURANCE YOU HAVE PROVIDED WILL BE BILLED FOR SERVICES RENDERED. YOU ARE RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT REGARDLESS OF ANY INSURANCE COVERAGE YOU MAY OR MAY NOT 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 ITS TERMS AND CONDITIONS.**

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____

DATE: _____