



1305 Escalante Drive, Ste. 201
 Durango, CO 81303
 Phone: 970-247-0042
 Fax: 970-259-8837

PATIENT INFORMATION, DISCLOSURE STATEMENT, & PAYMENT AGREEMENT

PATIENT - LAST NAME		FIRST NAME	MIDDLE NAME	PRONOUNS
PATIENT MAILING ADDRESS		APT. NO	CITY	STATE ZIP
E-MAIL ADDRESS		HOME PHONE ()		CELL PHONE ()
PATIENT STATUS <input type="checkbox"/> MAR <input type="checkbox"/> SINGLE <input type="checkbox"/> OTHER		DATE OF BIRTH	AGE	GENDER
PATIENT'S EMPLOYER				WORK PHONE / EXTENSION ()
RESPONSIBLE PARTY		PHONE		
IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY?		NAME	RELATIONSHIP	PHONE ()
RELATIVE 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: _____