SOUTHWEST Women's HEALTH ASSOCIATES
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 ☐ MAR ☐ SINGLE ☐ 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. BILLED CHARGES ARE DUE WITHIN 30 DAYS OF RECEIPT OF BILLING STATEMENT; PAYMENT NOT RECEIVED BY 30 DAYS WILL BE SUBJECT TO LATE FEES. IF YOUR ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY YOU WILL BE RESPONSIBLE FOR ALL ASSOCATED FEES INCLUDING LEGAL FEES. 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. WE REQUIRE THAT YOU CALL TO CANCEL AT LEAST 24 HOURS BEFORE YOUR SCHEDULED APPOINTMENT TIME. THERE IS A **$25** FEE IF YOU MISS YOUR APPOINTMENT OR DO NOT CANCEL AT LEAST 24 HOURS BEFORE SCHEDULED APPOINTMENT TIME. **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: _____

Revised 04-04-2024