The Women's Health Center, P.L.L.C.

David Hubbs, M.D. ~ Kevin Richardson, M.D. ~ Louise Gombako-Amos, M.D. ~ Tara Price, WHNP-BC

Please PRINT when filling out the information below

PATIENT INFORMATION

Patient Name: ______________________________

Date of Birth: ____/_____/_____ **Social Security #** _____/_____/_____ **Gender:** Male/Female

Mailing Address: ______________________________

City: ____________________ **State:** ___________________ **Zip Code:** ________________

Physical Address (if different):

____

City: ____________________ **State:** ___________________ **Zip Code:** ________________

Home Phone: __________________________ **Work Phone:** _________________________

Cell Phone: ____________________________ **Email:** ______________________________

I prefer to be reached by: (circle one) Cell Phone Home Phone Work Phone Email

Race: (circle one) Black White Hispanic Other: ____________________ Decline

Primary Language: _______________________ **Religion:** ____________________________

Marital Status: (circle one) Single Married Divorced Separated Widowed

My Preferred Drug Store is:

____

Emergency Contact Name: _________________________ **Phone Number:** ________________

Relationship to Patient:

____

INSURANCE

If your insurance company <u>does not pay</u> for the services rendered on the day of service who will be financially responsible

Financially Responsible Party*: _____________________ **Social Security #:** _____/_____/_____

Relationship of Responsible Party to Patient: ______________________ (self, spouse, child, other)

Insurance Company Name: ______________________________

Policy Holder's Name: ______________________________

Policy Holder's Social Security #: ____/____/____**Policy Holder's Date of Birth:** ____/____/____

Please fill out the information on the back of this page

Patient Name: ____

R
E
L
E
A
S
E

O
F

I
N
F
O
R
M
A
T
I
O
N

Authorization to Release Information

I hereby authorize the release of any medical information necessary to process claims or coordinate my medical care with health care providers/hospitals/disability companies. In the event that a dispute arises regarding payment for services between my physician and my insurance company, I give my permission for The Women's Health Center to access my medical records if necessary to resolve the matter. I also authorize my insurance benefits be paid to The Women's Health Center, PLLC. I understand that I am financially responsible for non-covered services.

Signature: ___________________________________ Date: ____________________

Authorization to Share "Protected Health Information: (P.H.I)

Purpose: To permit The Women's Health Center, P.L.L.C. to share my personal health information with the persons listed below:

Name: ___________________________________ Relationship: __________________

Name: ___________________________________ Relationship: __________________

Name: ___________________________________ Relationship: __________________

*This authorization will expire only upon receiving written notification from me.

Acknowledgement: I, hereby, permit The Women's Health Center, P.L.L.C. to share the following "Protected Health Information" concerning me.

- Health information concerning appointments; all past, present and future health information
- Any and all laboratory results and other diagnostic results (eg. x-ray, ultrasound, bone scan, etc.)
- Confirmation of appointment details

I understand that my "Protected Health Information" may be shared with people listed and that they may not be required to comply with federal health information laws. I understand that they practice reserves the right to deny access. In addition, authorized individual(s) must present identification as proof that they are who they claim to be.