Women's Pelvic Care

PATIENT INFORMATION FORM

PATIENT'S NAME (Should Match Insurance) AGE:	DATE OF BIRTH:
COMPLETE ADDRESS: (Include City, State, Zip Code)	SOCIAL SECURITY NUMBER:
HOME PHONE: ( ) CELL PHONE: ( ) WORK PHONE: ( )	PRIMARY PHARMACY:
EMAIL:	LOCATION:
Preferred Method of Communication: ☐ Home Phone ☐ Cell Phone ☐ Email	CROSS STREETS:
You may contact me or leave messages containing specific Health Information on (check one): ☐ Home Phone ☐ Cell Phone ☐ Work Phone	PHONE:
PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other:	
RACE (check one): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Caucasian/White ☐ Native Hawaiian/Pacific Islander ☐ Other	ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined
MARITAL STATUS (check one): ☐ Single ☐ Married ☐ Domestic Partner ☐ Widowed ☐ Divorced	
PRIMARY CARE PHYSICIAN + PHONE :	PATIENT EMPLOYER:

INSURANCE COMPANY:	POLICY HOLDER NAME:	PATIENT RELATIONSHIP + DATE OF BIRTH:

PAYMENT POLICY

I, the undersigned certify that I (or my dependent) have insurance coverage with the above referenced Insurance company(ies) and assign directly to Women's Pelvic Specialty Care, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance and I further agree that in the event payment for my services are denied by my insurance because of my failure to follow the guidelines and/or obtain required documents and/or referrals, that I will be responsible for the charges connected with my services. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

It is your responsibility to understand the benefits offered by your insurance plan. Many plans have changed requiring a deductible or coinsurance to be applied when certain tests or procedures are performed in addition to co-pays for your office visits. For example: If a medical issue is discovered during your annual visit, there may be a copay or additional charges required by your insurance company. Also, not all lab tests are covered by insurance so it is important for you to know what will be covered as you could be responsible for a separate bill from the laboratory for all or part of the costs. Please be advised that a precertification or prior authorization from your health plan is not a guarantee of payment. Copayments are due at the time of service along with any outstanding balance from previous visits and you are responsible for giving us current insurance information. (Including any secondary plans/coverages)

We will confirm your appointment two days prior and we ask that you give us **24 hour notice** if you're unable to keep your appointment. **A fee of $50 will be assessed for appointments missed without proper prior notification.**

I understand that I will be billed for any balance due after my insurance pays. I also understand and agree that I am responsible for full payment of my medical debt if my insurance company has refused to pay within 90 days of any and all appeals or requests for information. If I do not pay my balance due within 90 days and my account is turned over to a collection agency I will be responsible for possible interest penalties in addition to the full outstanding balance to Women's Pelvic Specialty Care of New Mexico.

RESPONSIBLE PARTY NAME:	SIGNATURE:	DATE OF BIRTH:	TODAY'S DATE: