



WESTSIDE WOMEN'S CARE, LLP

A Partnership of Professional Corporations

CONFIDENTIAL INFORMATION (PLEASE PRINT)

DATE _____

(PLEASE COMPLETE BOTH COLUMNS)

Patient Information

Insurance Information

PATIENT'S NAME		MARITAL STATUS	INSURANCE CO. NAME	
DATE OF BIRTH	AGE	SS #	POLICY HOLDER'S NAME	
STREET ADDRESS			POLICY HOLDER'S SS #	
CITY AND STATE	ZIP CODE	HOME PHONE #	POLICY HOLDER'S ID #	
PATIENT'S EMPLOYER		HOW LONG EMPLOYED	POLICY HOLDER'S DOB	
PATIENT'S OCCUPATION		INDICATE IF STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	POLICY HOLDERS GROUP #	EFFECTIVE DATE
EMPLOYER'S STREET ADDRESS			SECONDARY INSURANCE CO. NAME	
CITY AND STATE	ZIP CODE	BUS PHONE #	POLICY HOLDER'S NAME	
SPOUSE OR PARENT'S NAME (PLEASE CIRCLE ONE)			POLICY HOLDER'S SS#	
SPOUSE OR PARENT'S EMPLOYER			POLICY HOLDER'S ID #	
EMPLOYER'S STREET ADDRESS			POLICY HOLDER'S DOB	
CITY AND STATE	ZIP CODE	BUS PHONE #	POLICY HOLDER'S GROUP #	EFFECTIVE DATE
EMERGENCY CONTACT NAME		PHONE #		
RELIGIOUS PREFERENCE			NAME YOU LIKE TO BE CALLED	
FAMILY PHYSICIAN OR PRIMARY CARE PHYSICIAN		PHONE #	REFERRED BY	

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Westside Women's Care to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance, and all collection costs should this account be assigned for collection. Note: A finance charge will be added to accounts 90 days or more delinquent.

I understand that it is MY RESPONSIBILITY to understand my insurance coverage and inform my doctors of any charges in that coverage. This includes knowing what services are covered and what facilities (hospital, laboratories) may be utilized.

I accept and understand the responsibility of notifying Westside Women's Care of any requirement by my insurance company of a 2nd opinion and/or pre-authorization prior to any hospital admission or surgical procedure, whether done in office or in hospital. I understand that it is also my responsibility to verify that a pre-authorization has been completed prior to any hospital admission or surgical procedure. Failure to do so renders me responsible for any portion of the bill not paid by my insurance company.

I also understand if I fail to get a referral, if necessary, I will be responsible for the charges.

DATE _____ SIGNATURE _____