Westside women's care

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 HOLDERS NAME
STREET ADDRESS	POLICY HOLDER'S SS #
CITY AND STATE ZIP CODE DAYTIME PHONE #	POLICY HOLDER'S ID #
EMAIL ADDRESS	POLICY HOLDER'S DOB
PATIENT'S EMPLOYER BUSINESS PHONE #	POLICY HOLDER'S GROUP # EFFECTIVE DATE
PATIENT'S OCCUPATION INDICATE IF STUDENT ☐ YES ☐ NO	SECONDARY INSURANCE CO. NAME
SPOUSE OR PARENT'S NAME (PLEASE CIRCLE ONE)	POLICY HOLDER'S NAME
SPOUSE OR PARENT'S EMPLOYER	POLICY HOLDER'S SS #
EMERGENCY CONTACT NAME PHONE #	POLICY HOLDER'S ID #
FAMILY PHYSICIAN OR PRIMARY CARE PHYSICIAN PHONE #	POLICY HOLDER'S DOB
RELIGIOUS PREFERENCE	POLICY HOLDER'S GROUP # EFFECTIVE DATE
REFERRED BY	

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Westside Women't 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 covereage and inform my doctors of any changes in that coverage. This includes knowing what services are covered and what facilities (hospital, laboratories) may be used.

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

DATE _____ SIGNATURE _____