CENTRAL PHOENIX WOMEN'S HEALTH CARE

☐ CAROL HAHN, M.D. ☐ DIANE SPIEKER, M.D. ☐ EMILY CYR, M.D.

PATIENT #_____ DATE _____

PATIENT INFORMATION

PATIENT'S NAME

Mrs. Miss Ms. Dr._____ ☐ CELL ( ) _____

PREFERRED NAME_____ ☐ **HOME PHONE** ( ) _____

ADDRESS_____ APT # _____

CITY_____ STATE _____ ZIP _____

BIRTH DATE_____ SSN_____ ☐ DIVORCED ☐ MARRIED ☐ SINGLE ☐ PARTNERED ☐ WIDOWED

EMPLOYER _____ WORK PHONE (____)_____ OCCUPATION _____

PREFERRED PHARMACY _____ ADDRESS_____ PHONE _____

NAME OF PRIMARY CARE PHYSICIAN _____ PHONE # (____) _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

PLEASE CHECK THE PREFERRED PHONE # TO CONTACT YOU

PARTNER OR PARENT (if applicable)

NAME _____ PHONE ( ) _____ RELATIONSHIP _____

EMPLOYER _____ WORK PHONE ( ) _____ OCCUPATION _____

DATE OF BIRTH _____ SS #_____

EMERGENCY CONTACT

NAME _____ PHONE ( ) _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE_____ ZIP_____

PLEASE COMPLETE INSURANCE INFORMATION

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

ADDRESS _____ ADDRESS _____

_____ _____

PHONE ( ) _____ PHONE ( ) _____

POLICY HOLDER NAME _____ POLICY HOLDER NAME _____

RELATIONSHIP TO PATIENT _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ EMPLOYER _____

ID # _____ GR # _____ ID # _____ GR # _____

POLICY HOLDER SEX ☐F ☐ M BIRTH DATE_____ POLICY HOLDER SEX ☐F ☐ M BIRTH DATE _____

CENTRAL PHOENIX WOMEN'S HEALTH CARE, LTD.

RELEASE OF INFORMATION AUTHORIZATION/ASSIGNMENT OF BENEFITS FOR MEDICAL PAYMENT OF SERVICES/ACKNOWLEDGMENT OF OFFICE POLICIES

Authorization for release of Information: I authorize CPWHC to disclose all or any part(s) of my medical record to my listed insurance companies and any provider or facility participating in my care.

Medicare Certification: I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided as state below.

Assignment of Benefits: I hereby authorize payment directly to CPWHC by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer. In the event I received payment from my insurance company for services at CPWHC, I will surrender the payment to CPWHC.

Insurance: CPWHC will file your insurance as a service to you. If our office does not hear from your insurance company within 60 days, we request your help in contacting your insurance company to resolve the payment delay. **The insurance plan is a contract between you and your insurance company. We must hold you responsible for any balances due.**

Payment of Services: I understand that I am financially responsible for all charges and fees related to my care. I further understand that payment in full is expected upon receipt of the first statement which may include co-payments, deductibles, and any service not covered by my insurance plan. In the event my account is referred to a collection agency I will be responsible for collection costs, including interest and reasonable attorney fees.

Health Insurance Portability and Accountability Act (HIPAA): I acknowledge that a copy of the HIPAA Notice of Privacy Practices was made available to me.

Valuables: I (we) understand that CPWHC is not responsible for valuables and personal property brought to the facility.

Medical Release Forms: I understand that information within my medical records is protected by law and the physicians and staff of **CPWHC WILL NOT** disclose any information to outside entities without my written consent, this includes my spouse and family members. **I also understand that any signed Medical Release forms are good for 1 year unless otherwise noted and therefore must be updated appropriately.** At this time, I authorize CPWHC to disclose my personal health information to the following persons:

Name:_____ **Relationship:** _____

Name:_____ **Relationship:** _____

OR

_____ **I DO NOT AUTHORIZE CPWHC** to release my personal health information to anyone other than myself, my physician or clinician and my insurance company(s).

Messages: I authorize CPWHC to leave a voice message to include personal health information at this number: _____
OR **I DO NOT** authorize CPWHC to leave a voice message including my personal health information._____Initials

Personal Information: I understand that it is my sole responsibility to keep CPWHC up to date regarding any changes with my address, contact numbers, insurance plans, etc.

Treatment: I understand that I am responsible for facilitating my care and that it is expected of me to be compliant with my treatment plan and communicate with CPWHC clinical staff if I am unable to finish my course of treatment.

Advanced Directive: I have an Advanced Directive and it is located _____
I do not have an Advanced Directive _____

I certify I have read and fully understand all of the above to include the release of information, insurance authorizations, assignment and payment of services that all information is current and correct and do hereby consent for medical treatment.

_____ _____

Patient or Responsible Party Signature **Date**