Women's Health Connecticut

www.womenshealthct.com

For Internal Use Only
PT ID Number
Last Verified _____

Patient Information

Last Name_____ First Name_____ M.I._____ Maiden or Nickname_____

Street Address_____ Apt._____ PO Box_____ City_____

State_____ Zip_____ DOB_____ Last Four Digits of SS#_____ Preferred Language_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Other **Ethnicity** ☐ Hispanic ☐ Non-Hispanic

Race ☐ Asian ☐ Black ☐ Caucasian ☐ Multi-Racial ☐ Native American ☐ Pacific Islands ☐ Other

Home phone:_____ **W**ork phone:_____ Ext_____ **C**ell Phone:_____
Primary # to call me: ☐ **H** ☐ **W** ☐ **C**

Email address_____ May we email you for other than medical reasons? ☐ Yes ☐ No

Employer Name_____ Employer Address_____

Occupation_____ If Student ☐ Full time ☐ Part time School Name_____

Insurance Information — Do you have health insurance? ☐ Yes ☐ No

Primary Insurance_____ Insurance Address_____

Policy #_____ Group #_____ Copay_____

Policy Holder_____ DOB_____ Relationship_____

Secondary Insurance_____ Insurance Address_____

Policy #_____ Group #_____ Copay_____

Policy Holder_____ DOB_____ Relationship_____

Complete for Policy Holder if other than self: Last Four Digits of SS#_____

Employer_____ Employer's Phone #_(_____)_____

Employer Address_____

Other Information

Primary Care Physician_____ Referring Physician_____

Primary Physician in This Office_____ Pharmacy Name & Phone_____

In case of Emergency/Urgent matter, we may contact: MUST BE COMPLETED (e.g. nearest relative preferably not living with you)

Name_____ Relationship_____ Phone #_(_____)_____

Clinical Research: We do clinical research to advance women's health. May we notify you of upcoming studies? ☐ Yes ☐ No

May we examine your medical record, and/or billing information to determine your eligibility for a Clinical Study? ☐ Yes ☐ No

Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Physicians for Women's Health LLC will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as costs including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I understand an acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

Signature of Patient or Parent of Minor **Date**

Medicare Authorization for Treatment, Payment & Healthcare Operations, Medicare Recipients Sign both Authorizations.

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized medicare benefits be made either to me or on my behalf to Physicians for Women's Health LLC for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

Patient's Signature **Date**

CT9999O116 Rev. 02/12

Notice of Privacy: ☐ Received ☐ Refused _____
Signature of Patient or Parent of Minor **Date**

May release protected health information to: _____
Name **Relationship**