SOUTH VALLEY WOMEN'S HEALTH CARE, PC
PATIENT INFORMATION

Name_____ Birth Date_____ Age _____

Street Address_____City_____

State_____ Zip Code_____ SSN#_____

Phone_____ Cell Phone_____ Occupation_____

Employer _____Work Phone_____

Pharmacy Name & Address_____

Primary Language_____Race_____Ethnicity_____

RESPONSIBLE PARTY

Name_____

Address_____

Relationship to Patient _____Phone_____

INSURANCE INFORMATION

Primary Insurance_____

Insurance Address_____

Policy/ID Number _____ Group Number_____

Policy Holder_____ Date of Birth_____

Patient Relationship to Policy Holder_____ SSN #_____

Policy Holder's Employer_____

Secondary Insurance_____

Insurance Address_____

Policy/ID Number _____Group Number_____

Policy Holder_____ Date of Birth_____

Patient Relationship to Policy Holder_____ SSN #_____

Policy Holder's Employer_____

OTHER INFORMATION

Emergency Contact_____

Relationship_____ Phone_____

Referred to this office by_____Phone_____

Please see back for financial policy

South Valley Women's Health Care
Financial Policy & Waiver

Thank you for choosing South Valley Women's Health Care for your medical needs. We are committed to providing excellent patient care. The following is an explanation of our Financial Policy, which you must read and sign prior to any medical evaluation or treatment.

1. Each patient is responsible to know the coverage of their insurance plan including: co-pays, deductibles, referral requirements, prior authorizations and provider participation. A valid insurance card is needed at each visit.
2. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to provide us with correct insurance information at each visit so that claims may be processed quickly and accurately.
3. Patients are required to pay 100% of services not covered by insurance at the time of service. On occasion your doctor may recommend treatment that may not be considered medically necessary by your insurance. You understand that this is done to provide you the best medical care and accept responsibility for any charges not paid by your insurance company for whatever reason.

$ If you are on Medicaid or any Medicaid HMO, you must have a current medical card at the time of your appointment, otherwise you will be considered a cash patient and must pay in full at the time of service. Medicaid and their HMOs do not pay for all services. By signing this, you accept responsibility for any services that they do not consider medically necessary and do not pay.

$ We reserve the right to charge interest on any account balance older than 60 days in the amount of 18% annually. If your account is more than 90 days delinquent it may be turned over to a collection agency and reported to the credit bureaus. This will take place if arrangements are not made or kept on your outstanding balance. In the event that any balance is not paid, you agree to pay collection costs including an additional collection fee of up to 36%, attorney fees and legal fees if any delinquent balance is referred to an agency.

$ A $25.00 fee will be charged on all returned checks.

I agree to and understand this policy and agree to make payment accordingly. I also authorize the release of any medical or other information necessary to process my claims and authorize payment directly to the physician or supplier. By signing below, you acknowledge receipt of this Financial Policy.

Signature_____ **Date**_____

Printed Name_____ **Relation to Patient:** _____