The Women's Medical Centers

Date: ______________________ Entered By: ______________________

Patient Information (PLEASE PRINT)

Name ______________________

Address (including apt. number) ______________________

City, State, Zip Code ______________________

1st Phone # ____________ 2nd Phone # ____________ 3rd Phone # ____________

Emergency Contact & Relationship ______________________ Phone ____________

Social Security # ______________________ Date of Birth ____________

Referring Physician ______________________ Marital Status: M S D W

Primary Care Physician ______________________ Student: Full Part

Employer Name and Address ______________________

Guarantor Information (IF OTHER THAN SELF)

Name ______________________

Address (including apt. number) ______________________

City, State, Zip Code ______________________

Home Phone ______________________ Work Phone ______________________

Social Security # ______________________ Date of Birth ____________ Gender: M F

Employer Name and Address ______________________

Insurance Information

Primary Ins. ______________________ Secondary Ins. ______________________

Policy #/Group # ______________________ Policy #/Group # ______________________

Eff./Exp. Dates ______________________ Eff./Exp. Dates ______________________

All office visit payments are due at the time of the visit by cash, check, Visa or Mastercard, unless prior arrangements have been made with our office.

I have completed the above registration and understand that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process claims resulting from my visits and request payment of benefits to the party who accepts assignment.

Patient Signature: ______________________ Copy to patient ( ) Aug. 2011 Revised

Parent (If minor) ______________________

Print-All, Inc. #22949

AUTHORIZATION

I. General Consent To Treatment:

I agree and consent to a physical examination by the patient's physician(s). I understand that additional diagnostic procedures and treatment may be recommended by the physician(s) and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or medical treatment.

II. Release of Information:

I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse, psychological treatment, psychiatric treatment, and HIV status, if applicable) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid (or their various intermediaries), and the insurance arrangement or third party named on this patient information form (or any of their agents or representatives), when such information is requested for payment, worker's compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this physician's office.

III. Assignment of Third Party Coverage

A. I authorize any third party payor to pay directly to the physicians providing services to the patient, all benefits due and payable as a result of services rendered.

B. I authorize assignment to the physician who has provided services to the patient the insured's rights to penalties and attorney's fees in the event that the insurer fails to timely pay such benefits in accordance with Louisiana Law (La R.S. 22:657).

IV. Acknowledgement of Responsibility to Pay for Services

I understand that the physician, will as a courtesy, file claims with insurance carriers and third party payors. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any third party payor unless there is specific written agreement the physician and the patient or between the physician and the payor.

V. Patient Information

You are advised that any medication, both prescribed and over the counter, can cause possible side effects, allergic reactions, or other adverse reactions. These risks are usually minimal. If any reactions occur while taking medication, it is your responsibility to notify a physician immediately.

Certain medications should not be taken during pregnancy, therefore, it is your responsibility to inform your medical provider if you may be pregnant.

As always, smoking is hazardous to your health. In addition, the use of tobacco products with certain medications can possibly cause medical problems.

VI. This authorization shall remain effective and in force throughout my association for medical services with Newco Women's Medical Center

______________________________ DATE

______________________________ PATIENT'S SIGNATURE
Signature implies that you have read and understand the above statements

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to ______________________________ for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

______________________________ PATIENT'S SIGNATURE