Women's Center of Blue Ridge

PATIENT INFORMATION: (Please Print) Today's Date: _____/_____/_____

Name: ____ **SS#:** ____________________

Address: ____

City: ______________________ State: ______________ ZIP: ______________

Home Phone: ________________________ Cell Phone: ________________________

Date of Birth: _____/_____/_____ Age: _______ Sex: _______ Marital Status: ____________

Employment Status: ❑ Employed ❑ Retired ❑ Unemployed Occupation: _______________

Employer: ______________________________ Work Phone: ____________________

Employer Address: ____

PARENT/RESPONSIBLE PARTY (*if different from patient*)

Name: ____ **SS#:** ____________________

Address: ____

City: ______________________ State: ______________ ZIP: ______________

Home Phone: ________________________ Cell Phone: ________________________

INSURANCE INFORMATION/POLICY HOLDER: Do you have insurance? ❑ **Yes** ❑ **No**

Primary Insurance: ________________________ Subscriber ID #: __________________

Group #: ______________________ ***Name of Cardholder***: ________________________

Date of Birth: ______/______/______ SS #: ____________________________________

Secondary Insurance: ________________________ Subscriber ID #: __________________

Group #: ______________________ ***Name of Cardholder***: ________________________

Date of Birth: ______/______/______ SS #: ____________________________________

OTHER INFORMATION:

Referred by: ________________________ Primary Care Physician: ____________________

Pharmacy of choice: ______________________________ Phone: ____________________

Do we have your permission to:

Leave a message on your answering machine at home? ❑ Yes ❑ No
Leave a message at your place of employment? ❑ Yes ❑ No
Discuss your medical condition with any member of your household? ❑ Yes ❑ No

In case of Emergency, whom should we notify? ____________________________________

Relationship to Patient: ____________________________ Phone: ______________________

********** **TURN OVER PAGE AND SIGN FORM PLEASE** **********

ASSIGNMENT OF BENEFITS:

I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled. This includes Medicare, private insurance, and other health plans to release payment to Blue Ridge Women's Center aka Dr. Chandler Mohan and/or Dr. Emad Atta. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the release of all of my medical records from other physicians and institutions in order that I may be given the appropriate care.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid Services (CMS, formerly HCFA) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place to the original signed assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (section 1128B of the Social Security Act and 31U.S.C.3801-3812 provides penalties for withholding this information.) We will file all claims as a courtesy to you and your insurance company(s) and all necessary documentation for claim processing.

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I wish to place the following restrictions on disclosure of my health information:

____ ____________________

Patient or Responsible Party Signature Date Signed

INTERNAL USE ONLY

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time):____

By (name and title): ____