Account #: ____________________

Date: ____________________ Physician: ____________________

UPDATE
PATIENT INFORMATION

Patient Name:

Last	First	Middle	Preferred	Maiden

Miss Mrs. Ms				F M
Prefix	Date of Birth	Social Security Number	Marital Status	Sex

Street Address:

Zip: City: State: County:

Mailing Address (if different from home address):

Zip: City: State: County:

( )	( )	( )	( )	
Home Phone	Work Phone	Cell Phone	Pager Number	Email Address

College/School Attending (if Student):

School Enrollment Status: Full Time Part Time

Patient's Employer: Phone: ( )

Employer Address:

Zip: City: State: County:

Patient's Occupation:

Spouse's Name:			
Last	First	Date of Birth	Social Security Number

Spouse's Employer: Phone: ( )

Person Responsible for Bill Name:

Last	First	Middle

( )	( )	( )		
Home Phone	Work Phone	Cell Phone	Date of Birth	Social Security Number

Street Address:

Zip: City: State: County:

Mailing Address:

Zip: City: State: County:

Employer:	Self Spouse Father Mother Other
	Relationship to patient (if any):

Emergency Contact Name:

Last	First

Address:

Zip: City: State: County:

( )	( )	( )	Spouse Father Mother Other
Home Phone	Work Phone	Cell Phone	Relationship to patient (if any):

Please Allow the Receptionist to Copy Your Insurance Card   **Account #:** ____________________

INSURANCE INFORMATION

Primary Insurance Company Name:				
Mail Claims to:				
Zip	City:	State		
Policy Holder's Name:				
Last	First		Date of Birth	Social Security Number
Policy Holder's Employer Name:				
Relationship to patient (if any): Self	Spouse	Father	Mother	Other
Policy #:		Group #:		

Secondary Insurance Company Name:				
Mail Claims to:				
Zip	City:	State		
Policy Holder's Name:				
Last	First		Date of Birth	Social Security Number
Policy Holder's Employer Name:				
Relationship to patient (if any): Self	Spouse	Father	Mother	Other
Policy #:		Group #:		

Tertiary Insurance Company Name:				
Mail Claims to:				
Zip	City:	State		
Policy Holder's Name:				
Last	First		Date of Birth	Social Security Number
Policy Holder's Employer Name:				
Relationship to patient (if any): Self	Spouse	Father	Mother	Other
Policy #:		Group #:		

PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR OR STUDENT

Mother's Name:			
Last	First	Date of Birth	Social Security Number
Father's Name:			
Last	First	Date of Birth	Social Security Number

PAYMENT OF BENEFITS

All of the information included on this Patient Information form is complete and accurate to the best of my knowledge, and I certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I authorize that payment of medical benefits is made to the physician and/or organization for that physician and/or organization, as directed by the physician and/or organization. I have read and understand the payment policy of Woman's Group of Meridian. I will direct any questions I may have concerning this policy to the Patient Accounting Department before I leave today. I understand that I am responsible for any amount not covered by my insurance company.

SIGNATURE: ____________________ DATE: ____________________

and/or Parent, If Patient under 18

Account #: ____________________

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

PAYMENT POLICY: Patients are expected to make payment in full for office services at the time of the visit. For your convenience, we accept cash, checks, VISA, and MasterCard. We understand that circumstances sometimes do not make it possible for you to pay in full. When this happens, payment arrangements will be made with our Financial Counselor. Patients who have insurances contracted with us are responsible for any co-payment or deductible at the time of service. Any balance remaining on one of these accounts after insurance payments have been received will become the responsibility of the patient. Accounts with delinquent balances could be reported to the credit bureau or turned over to our collection agency if little or no effort has been made by the patient to settle the amount owed. There will be a $30.00 NSF fee charged to patient's account for any checks returned.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize above office to use my medical information for treatment, payment, and healthcare operations, including submitting information to my insurance company, The Centers for Medicare and Medicaid Services, or the Division of Medicaid or its Fiscal Agent for the purpose of processing claims. I permit the following to be used in place of this document for all federal, state, and private commercial health insurance claims: (1) Photocopy or other facsimile reproduction of this authorization, or (2) Use of computer to indicate my signature is onfile at above office, and/or (3) Use of a computer to transmit my insurance claim by phone for processing.

CERTIFICATION/AUTHORIZATION OF INSURED: I certify that the insurance information I have provided above office to be true and correct to the best of my knowledge. I authorize payment for services rendered to the doctors associated with the above office. I understand that the doctor(s) cannot accept responsibility for collecting my insurance claim or for negotiating a settlement on a disputed claim. I am responsible for payment of my account in full within the terms of the above payment policy. If I am under 18, the parent/guardian requesting treatment assumes responsibility. I understand that if my account should ever require action by a collections agency in order to collect the balance owed, fees charged by this agency may be added to the balance due on my account.

CONSENT FOR TREATMENT: I authorize the doctors and Woman's Group of Meridian and its designees to provide treatment. I further authorize labs, radiology centers, Pathologist and Radiologists who may interpret and report on diagnostic tests, and Anesthesiologists who will administer anesthesia during a scheduled procedure, to provide such treatment, if such tests/procedures are ordered by my doctor(s). I authorize above office to release all or part of my records to (1) Physicians to whom I am being referred, and/or (2) Any in- or out-patient facility where I am scheduled to receive treatment.

Please be advised that your medical history is strictly confidential. Absolutely NO information will be released without proper legal consent, unless so deemed by laws of this state.

We may contact you regarding appointment reminders, health care related information, and/or your account information: I authorize above office to contact me to notify me of a pending appointment or other health care related communication. I also authorize above office to disclose to third parties who answer my phone limited information regarding pending appointments, and to leave a reminder message on my answering machine.

A "Notice of Privacy Practices" provides a more complete description of the way your medical record might be used and can be obtained, at your request, at the front desk.

I understand that the clinic's policies about using information might change from time to time and that I can obtain another copy of the notice any time I so desire. I know that I can request restrictions on the way my health care information is used, but I also understand that the clinic is not required to abide by my restrictions.

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment, and health care operations. You can revoke this consent and the date of revocation.

I have received and had an opportunity to ask question concerning the "Notice of Privacy Practices for Protected Health Information.

Print Name	Lifetime Signature	Date