

PATIENT INFORMATION SHEET

***** PERSONAL DATA *****

PLEASE PRESENT A CURRENT INSURANCE CARD(S) AND A PHOTO ID AND COMPLETE THE REQUESTED INFORMATION

ACCOUNT # (For Office Use): _____

NAME: _____
FIRST MIDDLE MAIDEN LAST

NAME YOU PREFER TO BE CALLED _____

SOCIAL SECURITY #: _____ AGE: _____ DATE OF BIRTH _____

MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____

ADDRESS: _____ RACE: _____ RELIGION: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PH.: () _____ WORK PH.: () _____ CELL PH.: () _____

EMPLOYED BY: _____ OCCUPATION: _____

REFERRED BY: _____ FAMILY PHYSICIAN: _____

***** SPOUSE OR PARTNER DATA *****

NAME: _____ AGE: _____ DATE OF BIRTH: _____

OCCUPATION: _____ SOCIAL SECURITY #: _____

EMPLOYED BY: _____ WORK HONE #: () _____

***** INSURANCE DATA *****

INSURANCE COMPANY NAME POLICY ID # GROUP # NAME OF INSURED

PRIMARY: _____

SECONDARY: _____

***** EMERGENCY DATA *****

IN CASE OF EMERGENCY, PLEASE NOTIFY (OTHER THAN HUSBAND):

NAME: _____

ADDRESS: _____

PHONE #: () _____

GUARANTEE OF ACCOUNT: I HAVE READ THE FINANCIAL POLICY STATED ON THE REVERSE SIDE. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL CHARGES MADE TO MY ACCOUNT. I HEREBY AUTHORIZE WEST GEORGIA HEALTHCARE FOR WOMEN, P.C. TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO WEST GEORGIA HEALTHCARE FOR WOMEN, P.C. FOR SERVICES RENDERED AS DISCUSSED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED OR EXCLUDED BY ASSIGNED INSURANCE. MY SIGNATURE ON THIS FORM VERIFIES MY PRESENCE AND CONTINUATION OF BENEFITS ASSIGNED. I HAVE READ AND UNDERSTAND THE ABOVE AND GIVE WEST GEORGIA HEALTHCARE FOR WOMEN, P.C. PERMISSION TO TREAT ME. PLEASE SIGN AND DATE THIS FORM BELOW.

SIGNATURE OF PATIENT/GUARDIAN DATE
METHOD OF PAYMENT: CASH _____ CHECK _____ CREDIT CARD _____
CIRCLE ONE: VISA M/C DISCOVER AMERICAN
ACCOUNT #: _____ EXPRESS
EXPIRATION DATE: _____

PLEASE READ THE FINANCIAL POLICY ON THE REVERSE SIDE. ➡

West Georgia Healthcare For Women, P.C.

FINANCIAL AND PAYMENT POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy that we would like you to read prior to any treatment.

ALL patients must complete our patient information sheet on a yearly basis and provide a current insurance card(s) and a photo ID before seeing the physician. It is the patient's responsibility to inform us of any demographic or insurance changes.

DEDUCTIBLES, CO-INSURANCE AN CO-PAYS ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS.

We must emphasize that as physicians our relationship is with you, not you insurance company. We file the insurance claim as a courtesy to our patients, but all charges are your responsibility from the date the services are rendered. Not every service is a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is important that you read and understand YOUR health insurance policy and its requirements for coverage including preauthorization of services. We currently send claims to hundreds of plans and are not responsible for knowing the requirements of your specific plan. We do not file insurance claims for plans we do not participate with.

MANAGED CARE AND PPO PLANS

We participate with most managed care plans and file insurance claims as per our agreement with those plans, but we do expect co-pays, deductibles and non-covered or excluded services to be paid in full at the time of service. Insurance policies may change and/or insurance company representatives do not always give us correct or consistent information. In the event that your claim is denied because of an insurance error, or due to a non-covered service, the patient is financially responsible for all services rendered.

MEDICARE

We do accept assignment on Medicare, but ask that you pay for non-covered services and deductibles at time of service. We will bill your secondary insurance as a courtesy to you. **PLEASE BE ADVISED:** Preventive and screening exams are not covered by Medicare and payment is expected in full at time of service.

MEDICAID

We **ONLY** accept GYN Medicaid with a referral from your Primary Care Physician who must provide us with a referral number. We are not accepting any OB Medicaid at this time as our panel is closed.

PREGNANCY RELATED CHARGES

Patient deductibles, co-payments and co-insurance amounts are due in full by the 32nd week of pregnancy. A payment schedule will be mailed to you after your first visit, with the first payment being due the following month. If you have question before your appointment, please call.

SURGERY PAYMENTS

An **estimate**, based on information provided by your insurance company, will be done at the time surgery is scheduled and you will be responsible for payment of any deductibles, co-payments or co-insurance at the preop visit.

MISCELLANEOUS

A \$25.00 NSFC will be charged for a returned check, which must be rectified with cash, money order, or credit card.

Turn over 