DATE:
Referring Physician:

PATIENT INFORMATION

1 PATIENT

Patient Name:

Last	First	Middle	Preferred	Maiden

Race/Ethnicity	Date Of Birth	Social Security Number	Marital Status	Sex (F M)

Street Address:

Zip: City: State: County:

Mailing Address:

Zip: City: State: County:

Home Phone	Work Phone	Cell Phone	Email Address

Patient's Employer: Phone: ( )

Employer Address:

Zip: City: State: County:

Patient's Occupation: Driver's License #:

2 PHARMACY

Preferred Pharmacy

Pharmacy Name:

Address:

Zip: City: State: County:

Phone:

3 BILLING INFO

Person Responsible for Bill:

Last: First: Middle:

Date Of Birth	Social Security Number	Work Phone	Cell Phone	Home Phone

Street Address:

Zip: City: State: County:

Mailing Address:

Zip: City: State: County:

Employer:

Employer Address:

Zip: City: State: County:

4

Emergency Contact Name: Relationship to Patient

Phone#:

Insurance Information

Primary Insurance Company:			
Mail Claims to:			
Zip:	City:	State:	
Policy Holder's Name:			
Last	First		Social Security Number
Policy Holder's Address:			
Zip:	City:	State:	County:
Phone:	Relationship to patient (if any):		Date of Birth:
Policy #:		Group #:	
Effective Date of Policy:			

Secondary Insurance Company:			
Mail Claims to:			
Zip:	City:	State:	
Policy Holder's Name:			
Last	First		Social Security Number
Policy Holder's Address:			
Zip:	City:	State:	County:
Phone:	Relationship to patient (if any):		Date of Birth:
Policy #:		Group #:	
Effective Date of Policy:			

PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR OR STUDENT

Father's Name:				
Last	First		Date Of Birth	Social Security Number
Father's Employer:				Phone:
Employer Address:				
Zip:	City:		State:	County:
Mother's Name:				
Last	First		Date Of Birth	Social Security Number
Mother's Employer:				Phone:
Employer Address:				
Zip:	City:		State:	County:

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 have read and understand the payment policy of Women's Pavilion of South Mississippi. 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. I have been offered and had an opportunity to ask questions concerning the Practice's Notice of Privacy Practices for Protected Health Information.

SIGNATURE: DATE:

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 Patient Accounting Department. Patients who have insurances contracted with us are responsible for any co-payment or deductible at the time of service. All estimated fees for scheduled surgery or in-office procedure will be collected in full prior to the surgery or procedure. Any balance remaining on accounts after insurance payments have been received will become the responsibility of the patient. Accounts with delinquent balances over 90 days 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.

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 on file at above office, and/or
(3) Use of a computer to transmit my insurance claim by phone for processing.

➢ Patient Print Name ______________ Guardian Print Name ______________ Relationship to Patient ______________

➢ Patient Signature ______________ Guardian Signature ______________ Date ______________

CERTIFICATION/AUTHORIZATION OF INSURED: I certify that the insurance information I have provided the above office to be true and correct. I understand that if I do not provide all of my active insurance policy information, I will be responsible for any balance incurred. I authorize payment for services rendered to the providers associated with the above office. I understand that the provider(s) cannot accept responsibility for collecting my insurance claims 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 collection agency, a 30% collection fee may be added to the balance due on my account.

I authorize the provider(s) of above office and its designees to provide treatment. I further authorize labs, radiology centers, pathologists and radiologists who may interpret and report on diagnostic tests, and anesthesiologists who will administer anesthesia during a scheduled procedure to provide treatment, if such tests/procedures are ordered by my provider(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.
(3) Prescription information via e-Rx to Pharmacies.

I understand that WPSM uses electronic prescribing and that prescriptions will be sent and medication history may be obtained electronically.

I authorize above office to use an automated messaging system and to use my name, address, and phone number; the name of my scheduled treating provider; and the time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare 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.

➢ Patient Print Name ______________ Guardian Print Name ______________ Relationship to Patient ______________

➢ Patient Signature ______________ Guardian Signature ______________ Date ______________

MEDICAL / FINANCIAL INFORMATION DISCLOSURE

Date: ______________________________________

I, ______________________________, the undersigned, hereby authorize Women's Pavilion of South Mississippi, PLLC, its representatives, physicians, and staff to share any and all medical and financial information with the following individual(s). The individual(s) listed below are involved in my care and have authorization to talk to staff on the phone or in person.

☐ At this time I do not want to authorize anyone other than myself.

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

I understand that authorization to anyone other than myself is voluntary and I can revoke authorization at any time by completing a new copy of this form.

Patient Name: ______________________________ Date: ________________

Patient Signature: ____