WATERVILLE WOMEN'S CARE

Date:_____ Home Phone:_____ Work Phone:_____ Cell Phone:_____

Last Name: _____ First Name:_____ DOB:_____ SSN_____

Mailing Address:_____

*IF INTERESTED IN OUR PATIENT PORTAL PLEASE PROVIDE YOUR EMIAL ADDRESS:*_____

Preferred contact number for confirmation calls: _____ Method for confirmation calls: (circle one) VOICE TEXT

Marital Status: (Circle One) SINGLE MARRIED WIDOWED SEPARATED DIVORCED

Race (Circle One): White African American Asian Native American Alaskan Native Other

Primary Language (Circle One): English Spanish German French Other:

Patient's Employer:_____ Address:_____

Business Phone:_____ Occupation: _____

Spouse/Partner's Name:_____ DOB:_____ SSN:_____

Business Name:_____ Occuaption: _____ Phone:_____

Name of Primary Care Provider:_____ ***Name of Pharmacy:***_____

In case of emergency, who should be notified? _____ Phone:_____

Do you have medical insurance? YES NO Name of Policy Holder: _____

Insurance Certificate/Policy #:_____ ***Group #:***_____

ASSIGNMENT AND RELEASE I, the undersigned have insurance with _____ and assign directly to Augusta & Waterville Women's Care all medical benefits. If any, otherwise payable o me for services rendered, I understand that I am financially responsible for all the charges whether or not paid by the insurance. I authorize the use of this signature on all my submissions.

_____ _____

Signature of Insured/Guardian Date

In the event that your balance is not paid in a timely fashion, you will be held liable for any costs of collection, interest, fees or legal expenses incurred in the collection of your account. If the account is sent to a collection agency, we will add 29% to your balance.

MEDICARE AUTHORIZATION I request that payment of authorized Medicare benefits be made to me on my behalf to Augusta & Waterville Women's Care for any services furnished to me by that physician. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms submitted, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assignment cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services; coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Beneficiary Date