EXCEPTIONAL CARE FOR WOMEN

*****PLEASE FILL OUT COMPLETELY*****

Date: _____

Usual provider (please select from the drop down list): Dr Ryan

Patient's full name: _____ SSN: _____

Street address: _____ Home Phone: _____☐ leave message?

City: _____ State: _____ Zip: _____ Work Phone: _____☐ leave message?

Date of birth: _____ Cell Phone: _____☐ leave message?

Email address: _____ Preferred method of contact: ☐Home ☐ Work ☐ Cell

Former/maiden name: _____ Marital: ☐ S ☐M ☐ D ☐W ☐ Separated

Preferred Pharmacy: _____ Employer: _____

Primary care provider/referring doctor: _____

Emergency contact: _____ Phone/type: _____☐Home ☐ Work ☐ Cell

Relationship to contact: _____

*****PERSON RESPONSIBLE FOR INSURANCE*****

(If different from above)

Policy holder's full legal name: _____ Home: _____

Address: _____ Work: _____

City: _____ State: _____ Zip: _____ Cell: _____ _____

Date of Birth: _____ SSN: _____ Relationship to patient: _____

*****INSURANCE INFORMATION*****

****Insurance cards MUST be provided at the time of service for billing purposes****

☐ **Self Pay (no insurnace)**

Primary insurance name: _____ ID#: _____

Group #: _____ Policy holder's name: _____

Insurance Mailing Address: _____

Secondary insurance name: _____ ID#: _____

Group #: _____ Policy holder's name: _____

Insurance Mailing Address: _____

Over please

*****DEMOGRAPHICS*****

Optional: RACE/ETHNICITY two part Question.

Please answer BOTH questions. (Check as many as apply) OR Decline_____ ("X" if you decline to answer)

Do you consider yourself to be Hispanic or Latino according to the definition?
☐Yes, I am Hispanic or Latino- A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race

☐No, I am not Hispanic or Latino

What is your race? (regardless of how you answered the first question)

☐ American Indian or Alaska Native- A person having origins in any of the original peoples of North and South America (including Central America)

☐ Asian -A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam

☐ Black or African American -A person having origins in any of the black racial groups of Africa

☐ Native Hawaiian or Other Pacific Islander- A person having origins in any of the original peoples of Hawaii, Guam, Samoa, other Pacific Islands

☐White or Caucasian - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

☐More than one race

Preferred Language:

☐ English ☐ Spanish ☐ Other _____

*****FINANCIAL RELEASE*****

I understand that I am responsible for obtaining a referral or proper authorization from my insurance company for each surgery or delivery. It is my responsibility to know which hospital and/or lab my insurance will reimburse for services. Specimens such as Pap smear, tissue biopsy samples, genital cultures, blood samples or urine will be sent to an outside lab contracted through my insurance company. Therefore, an outside charge may be associated with these services. I agree that if the insurance company denies benefits for any reason, I will be responsible for the full amount of the service rendered. I also understand and agree to pay a $30.00 fee for any returned checks.

I request that payment of authorized insurance/Medicare benefits be made to Exceptional Care for Women (FEIN 26-2216328) for any services rendered. In the event that my account is turned over to a collection agency for non-payment, I agree to pay all reasonable attorney's fees and costs of collection and understand that I am no longer be able to receive care at this office.

I authorize any medical information about me to be released to any or all Health Care Financing Administration, its agents, or my insurance carrier as needed to process and pay my claims or those of my dependant. I have also been made aware of the privacy policies which are in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Patient's signature: _____ Date: _____

Printed name: _____