

A Renaissance In Women's Health Care, P.C.

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SS#: ____-____-____ BIRTHDAY: ____/____/____ HOME PHONE: _____

CELL PHONE: _____

MAY WE LEAVE A DETAILED MESSAGE ON YOUR HOME?	YES	NO
MAY WE LEAVE A CALL BACK NUMBER ONLY?	YES	NO
MAY WE LEAVE A DETAILED MESSAGE ON YOUR CELL?	YES	NO
MAY WE LEAVE A CALL BACK NUMBER ONLY?	YES	NO

MARITAL STATUS: M S D W FORMER NAME: _____

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____ WORK PHONE: _____

MAY WE CALL YOU AT WORK? Y N MAY WE LEAVE A MESSAGE FOR YOU AT WORK? Y N

SPOUSE/PARENTS(if minor) NAME: _____ PHONE: _____	
EMERGENCY CONTACT: _____ PHONE: _____	
PRIMARY INSURANCE NAME OF INSURANCE: _____ POLICY HOLDERS: NAME: _____ DOB: ____/____/____ SS#: ____-____-____ POLICY#: _____ GROUP#: _____ EMPLOYER: _____ PHONE: _____	SECONDARY INSURANCE NAME OF INSURANCE: _____ POLICY HOLDERS: NAME: _____ DOB: ____/____/____ SS#: ____-____-____ POLICY#: _____ GROUP#: _____ EMPLOYER: _____ PHONE: _____

MAY WE SPEAK TO SOMEONE ELSE REGARDING YOUR MEDICAL _____, FINANCIAL _____ OR APPT. _____?

NAME/PHONE NUMBER: _____ RELATIONSHIP: _____

FINANCIAL & INFORMATION RELEASE

I understand that I am responsible for obtaining a referral or proper authorization from my insurance company for each surgery or delivery. I am responsible to know which hospital and/or lab my insurance will reimburse. Specimens such as a Pap smear, biopsy tissue samples, genital cultures, or urine will be sent to an outside lab contracted through my insurance company. Therefore an outside charge may be associated with my procedures. I agree that if the insurance company denies benefits for any reason, I will be held responsible for the full amount of the services rendered. **I also understand and agree to pay \$35.00 returned check charge.**

I request that payment of authorized insurance/Medicare benefits be made payable to Rygiel's Renaissance on behalf for services furnished to me. In the event that my account is turned over to a collection agency, I agree to pay all reasonable attorney's fees and costs of collection and understand that I am no longer a patient 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 mine/my dependants claims. I have also been made aware of the privacy policies which are in compliance of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

PATIENT'S SIGNATURE: _____ DATE: _____