



CENTER FOR WOMEN'S HEALTH
A Division of Mid-Atlantic Women's Care, P.L.C.

IN ORDER FOR US TO PROVIDE YOU WITH COMPREHENSIVE, FAMILY ORIENTED HEALTH CARE, PLEASE SUPPLY THE FOLLOWING INFORMATION.

PATIENT INFORMATION

PATIENT INFORMATION

**RESPONSIBLE PARTY
SKIP IF SAME AS ABOVE**

SPOUSE

EMERGENCY

PHARMACY

INSURANCE CO. #1

INSURANCE CO. #2

MEDICARE PATIENTS ONLY

LAST NAME		FIRST NAME		MIDDLE INITIAL	SOCIAL SECURITY NO.	
ADDRESS & MAILING ADDRESS				CITY	STATE	ZIP CODE
SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> M <input type="checkbox"/> W	DATE OF BIRTH / /	AGE	MEDICINES ALLERGIC TO →		
HOME PHONE ()		WORK PHONE ()		CELL PHONE ()	OCCUPATION	EMPLOYER
EMPLOYER'S ADDRESS				CITY	STATE	ZIP CODE

LAST NAME		FIRST NAME		MIDDLE INITIAL	DATE OF BIRTH / /	SOCIAL SECURITY NO.
ADDRESS & MAILING ADDRESS				CITY	STATE	ZIP CODE
HOME PHONE ()		WORK PHONE ()		CELL PHONE ()		
RELATIONSHIP TO PATIENT		OCCUPATION		EMPLOYER		

LAST NAME		FIRST NAME		MIDDLE INITIAL	DATE OF BIRTH / /	SOCIAL SECURITY NO.
EMERGENCY CONTACT AT DIFFERENT ADDRESS				RELATIONSHIP	PHONE ()	
ADDRESS				CITY	STATE	ZIP CODE

PHARMACY NAME		PHONE ()	FAX ()
ADDRESS		CITY	STATE ZIP CODE

For your convenience, we will assist you or supply you with the information necessary to file your medical insurance. Please allow us to copy your insurance cards.			
COMPANY NAME		COMPANY NAME	
ID NO.	GROUP NO.	ID NO.	GROUP NO.
SUBSCRIBER'S NAME		DATE OF BIRTH / /	
RELATION TO PATIENT		RELATION TO PATIENT	

I WAS REFERRED TO THIS PRACTICE BY:

DEEMED CONSENT

Under Virginia law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transmit human immunodeficiency virus (HIV) or hepatitis B or C viruses, you shall be deemed to have consented to testing for infection with HIV or hepatitis B or C viruses. In addition, you shall be deemed to have consented to the release of such test results to the person who was exposed.

HIPAA Acknowledgement: All patients must initial one of the following:

_____ I hereby acknowledge that I have been provided with a copy of the MAWC Notice of Privacy Policies.

_____ I hereby acknowledge that I have been provided with a copy of the MAWC Notice of Privacy Policies but decline to accept it at this time.

SIGNATURE OF PATIENT / RESPONSIBLE PARTY	RELATIONSHIP TO PATIENT	DATE
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MAWC FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I hereby authorize treatment to patient by any MAWC provider and/or any affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for third party reimbursement from my insurance carrier, Tricare or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that the payor determines does not constitute covered services as well as attorney's fees of 33 1/3%, and any other related costs of collection should such action become necessary.

SIGNATURE OF PATIENT / RESPONSIBLE PARTY	RELATIONSHIP TO PATIENT	DATE
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BENEFICIARY NAME	<p>I request that payment of authorized Medicare benefits be made either to me or on my behalf to MAWC for any services furnished me by their physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.</p> <p>I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned 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. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.</p>
HICN #	
<p>IF YOU ARE A MEDICARE PATIENT, THIS SECTION MUST BE COMPLETED FOR PROPER PROCESSING OF YOUR ACCOUNT WITH THIS PRACTICE.</p>	
<p>_____ BENEFICIARY SIGNATURE _____ DATE _____</p>	