

**NORTHWEST WOMEN'S CONSULTANTS, S.C.
CONFIDENTIAL INFORMATION SHEET**

Preferred Pharmacy Name _____

Phone () _____

Mail Order Pharmacy Name _____

PATIENT INFORMATION

Please Print

Name _____
Last First Middle

Single Engaged Married Divorced Widowed Domestic Partner

Address _____
City State Zip

Home Land Line () _____ Work Phone () _____ Cell Phone () _____

Preferred Phone # (choose one) Home Work Cell Email Address _____
Case Sensitive

Date of Birth _____ Age _____

Employers Name & Address _____ Occupation _____

SPOUSE / PARENT INFORMATION

Spouse / Parent Name _____ Date of Birth _____ Social Security # _____

Employer _____ Work Phone () _____ Cell Phone () _____

INSURANCE INFORMATION

Primary
Policy Holder's Name _____ Date of Birth _____ Insurance Co. _____

Secondary
Policy Holder's Name _____ Date of Birth _____ Insurance Co. _____

OUR POLICY DOES NOT ALLOW US TO CHANGE THE DIAGNOSIS OR SERVICES AFTER THEY HAVE BEEN BILLED TO YOUR INSURANCE COMPANY.

I hereby authorize Northwest Women's Consultants S.C. to furnish information to insurance carriers concerning my illnesses and treatments and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. **I understand that I am responsible for any amount not covered by insurance.**

Confidential Communication

I hereby request Northwest Women's Consultants, S.C., to keep communications regarding my protected health information confidential.

Can we leave a DETAILED message with NORMAL results on answering machine and/or voice mail? Yes No

A copy of the Privacy Act is available at the front desk upon request.

If you are treated on or after Jan. 1, 2017 and you have a balance over 90 days old, you will incur a finance charge of 1.5% on the unpaid balance. My signature below acknowledges my financial responsibility.

Signature _____ Date _____
(Parent, if minor)