Waco Center for Women's Health

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PAYMENT FOR SERVICE IS DUE AND PAYABLE ON THE DATE OF SERVICE

PATIENT INFORMATION

Date_____

Patient Name_____Birthdate_____Age_____
Last First Middle

Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____

SSN_____/_____/_____ Driver License #_____

Employer_____Work Phone_____

Business Address_____City_____State_____Zip_____

Why did you choose Waco Center for Women's Health?_____

Guardian/Spouse's Name_____Birthdate_____Age_____

SSN_____/_____/_____ Employer_____Work Phone_____

Alternate Emergency Contact_____Relationship_____Phone_____

Referring Physician_____Family Physician_____

Has any family member been a patient here before? ☐ Yes ☐ No Who?_____Relationship_____

I authorize release of medical information to be given to_____Relationship to patient_____

Primary Ins. Co._____Sec. Ins. Co_____

Name of Insured_____ Relationship to Patient_____

Insured's Date of Birth_____SSN_____

Does your insurance require labs be sent to a specific lab?
YES NO

PATIENT ACKNOWLEDGMENT (Please initial each statement)

_____ I authorize direct payment of medical benefits to Waco Center for Women's Health. for services furnished to me.

_____ I permit a copy of this authorization to be used in place of the original.

_____ I certify the above information is true and correct and realize that I am financially responsible for all medical bills.

_____ A Notice of Privacy Practices describing my rights under HIPAA Law and the uses & disclosures of my protected health information has been made available to me.

_____ I consent to the use & disclosure of protected health information about me for the purposes of treatment, payment & health care operations.

Patient Signature_____Date_____