ADVANCED WOMEN'S HEALTH

Date_____
( ) New Patient ( ) Update

NAME (FIRST) _____ (MI)____(LAST)_____DOB_____
PREFERRED NAME_____SOCIAL SECURITY #_____
CURRENT ADDRESS_____APT#_____
CITY_____STATE_____ZIP_____
PRIMARY CONTACT NUMBER_____CELL ( ) HOME ( ) WORK ( )
SECONDARY CONTACT NUMBER_____ CELL ( ) HOME ( ) WORK ( )
OCCUPATION_____ EMPLOYER_____
MARTIAL STATUS ( ) SINGLE ( ) MARRIED ( ) PARTNER ( ) DIVORCED ( ) WIDOWED
NAME OF EMERGENCY CONTACT_____ ( ) SPOUSE ( ) PARENT ( ) OTHER
PRIMARY NUMBER FOR EMERGENCY CONTACT _____
SUBSCRIBER OF INSURANCE_____ DATE OF BIRTH_____
REFERRED BY ( ) DOCTOR ( ) INS. CO ( ) PHONEBOOK ( ) WEBSITE ( ) FRIEND_____
PRIMARY CARE PROVIDER_____ OFFICE NUMBER_____

PLEASE PROVIDE INSURANCE CARD AND PHOTO IDENTIFICATION AT EACH AND EVERY VISIT TO ENSURE CORRECT BILLING.

PLEASE READ AND INTIAL THE FOLLOWING:

_____ YOU MUST HAVE YOUR INSURANCE CARD AT EVERY VISIT.
_____ YOUR COPAY IS DUE BEFORE YOU ARE SEEN. IF NOT PAID A $25 BILLING FEE WILL BE ADDED TO YOUR ACCOUNT.
_____ YOU MUST GIVE 24 HOURS NOTICE TO RESCHEDULE/CANCEL AN APPOINTMENT OR THERE WILL BE A $85 FEE.
_____ THERE WILL BE A $50 CHARGE FOR ALL RETURNED CHECKS
_____ BALANCES ARE DUE WITHIN 10 DAYS OF STATEMENT DATE. PROCESSED ACCOUNTS WITH AN OUTSTANIDING BALANCE GREATER THAN 60 DAYS FROM DATE OF SERVICE WILL INCUR A $25 MONTHLY REBILLING ADMINISTRATIVE FEE. IN ADDITION, MONTHLY INTEREST WILL BE ADDED TO THE OUTSTANDING BALANCE, ACCUMULATING AT THE MAXIMUM ALLOWABLE AMOUNT BY LAW (CURRENTLY 1% MONTHLY).

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, AND DISCOVER FOR ALL PAYMENTS.

I authorize my insurance benefits to be paid directly to ADVACNED WOMEN'S HEALTH for services rendered. I also authorize ADVANCED WOMEN'S HEALTH to release any information requested by the insurance company with regard to payment of benefits. I acknowledge financial responsibility for all charges relating to my care at ADVANCED WOMEN'S HEALTH. I understand that I will be billed directly from other lab and/or x-ray facilities for the charges incurred for diagnostic services.

CREDIT POLICY: All charges are due within 30 days of the date on the statement unless prior arrangements have been made.

SIGNATURE_____ DATE_____

ADVANCED WOMEN'S HEALTH
2102 NORTH PEARL ST. SUITE 405 TACOMA, WA 98406

We value your privacy and the integrity of your protected medical information. Please inform us of your preferences regarding the release of your medical information.

ADVANCED WOMEN'S HEALTH may use or disclose the following health information (check all that apply):

( ) All my health information
( ) Only information for a specific health condition_____
( ) Exclude information about these listed conditions_____
( ) Only the information from these listed dates _____

The above information may be released to (check all that apply):

( ) Immediate family (ex: parents, children, siblings)
Names_____
( ) Spouse _____
( ) Able to leave detailed message at following number_____
( ) Do not release information to _____

You may revoke this authorization at any time in writing. If you do so, it will not affect any actions or information provided by ADVANCED WOMEN'S HEALTH based on the existing authorization and/or prior to the written revocation. You may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke authorizations are:

- **Fill out a revocation form (form is available from ADVANCED WOMEN'S HEALTH)**
- **Write a letter specifying your changes**

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy law no longer protects the information.

_____ _____
PATIENT SIGNATURE DATE
(13 YEARS AND OLDER SIGN FOR THEMSELVES)

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