

Willow Creek Women's Clinic S.C.

Date _____ Referring Physician/Clinic/Other _____

Social Security Number _____ Birth Date _____ Age _____

Name _____

Address _____ First _____ MI _____ Last _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Email: _____

May we contact you via email for appointment reminders or test results? : Yes ___ No ___

Employer _____ Position _____

Business phone _____ May we contact you at work? _____

Husband's Name _____

Husband's Birth Date _____ Social Security Number _____

Husband's Employer _____ Position _____

If a minor/student: Father's name _____ Work Phone _____

Mother's name _____ Work Phone _____

Address (if different): _____

Emergency contact (other than spouse):

1. _____ Relationship to patient _____ Phone _____

2. _____ Relationship to patient _____ Phone _____

INSURANCE INFORMATION – Please fill out completely

Primary insurance carrier _____ Effective date _____

Primary cardholder _____ Relationship to patient _____ DOB _____

Policy number _____ Group number _____

Group name/employer _____

Secondary insurance carrier _____ Effective date _____

Secondary cardholder _____ Relationship to patient _____ DOB _____

Policy number _____ Group number _____

Group name/employer _____

FINANCIAL POLICY (Please read and sign)

You should look upon your insurance policy realistically as a device which may reimburse you for medical services.

As a courtesy to you, we will complete the forms necessary pertaining to your claim and submit them to your insurance carrier. As we are not a party to the agreement between you and your insurance carrier, we are not responsible for how much and when they pay your claim. You are responsible for payment of any deductible, co-payment, and any estimated balance not payable by your insurance company. The remainder of the bill is to be paid 45-days from the date services are provided.

If you do not have insurance coverage, we expect payment at the time of service. If this is not possible, we ask that you make financial arrangements prior to your appointment. The bill is to be paid in full within 45-days from the date services are provided.

I authorize my insurance company to make payment for medical expenses to my doctor for service performed.

I authorize release of medical information to my insurance company as required.

Signature: _____ Date: _____

Patient and/or Guardian