

# Southcoast Woman's Care

Michelle L. Hughes, M.D., FACOG • Constance Gillett, RNC, MS

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Maiden: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Spouse: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

## IN CASE OF AN EMERGENCY:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that any payment of authorized benefits be made on my behalf, I assign the benefits payable to which I am entitled, including Medicare and private insurances and other health plans, to Southcoast Woman's Care. This agreement will remain in effect until revoked by me in writing. A photocopy of the agreement is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

SIGNATURE: X \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

- I acknowledge that I have received a copy of the HIPAA Privacy Policy pamphlet.

SIGNATURE: X \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

- I request that of authorized Medicare benefits be made to me or on my behalf to Southcoast Woman's Care for any services rendered. I authorize any holder of medical information about me be release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
- I request that payment of authorized insurance benefits be made on my behalf to Southcoast Woman's Care. I authorize the release of this information to third party payers. I agree that I will be responsible for payment of any services that are not covered by my insurance company.
- **AUTHORIZATION TO GIVE MEDICAL CARE:** I hereby authorize the undersigned MD/NP to render medical treatment.

SIGNATURE: X \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_