Willow Creek Women's Clinic S.C.

Date ____________________ How did you find our clinic? ____

Social Security Number ____________________________ Birth Date ______________________ Age ___________

Name ____
First MI Last

Address ____ Home Phone _________________________

City _________________________ State _____ Zip ______________ Cell Phone ___________________________

Marital Status: _____________ Email: ____

May we contact you via email for reminders, test results or other communications? : Yes_____No______ (Note: Please do not email us with sensitive information ie: Social Security or credit card numbers – email not secure)

Employer ______________________________________ Position ______________________________________

Business phone _______________________________ May we contact you at work? _________________________

Partner's Name ____

Partner's Birth Date ________________________ Social Security Number ________________________________

Partner's Employer _____________________________________ Position _______________________________

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

Mother's name _________________________________ Work Phone _______________________

Address (if different):____

Emergency contact (other than partner):

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