Southcoast Woman's Care

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Date___/___/___

Name:______________________________ Maiden:_________________________

Address: ________________________City/State: ___________________ Zip Code: ______

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 Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable to 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:**____________

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