Circle of Life Womens Center
Tenderness with Technology

Patient Information

Name (Last, First Middle)	SSN #	Birthdate	Sex
Mailing Address	City, State, Zip		
Home Phone	Day Phone	Email Address	

Marital Status	Student Status □Full- Time □Part-time	Smoker Yes / No	Veteran Yes / No	Primary Care Provider

Employer Occupation	Emergency Contact (person not living with you) Name
Address	Relationship Address (City/State Only)
Work Phone	Phone Number

Spouse or Guarantor Information (for persons under 18)

Name (Last, First Middle)	SSN #	Birthdate	Sex
Mailing Address	City, State, Zip		
Home Phone	Day Phone	Email Address	

Marital Status	Student Status □Full- Time □Part-time	Smoker Yes / No	Veteran Yes / No	Primary Care Provider
Relationship to Patient				

Primary Insurance

Name of Insurance Company	Policy #
Name of Policy Holder Policy Holder Date of Birth	Group #
Claim Address of Insurance Company	Copay Amount (specialist)

City, State, Zip	Phone	Deductible
Relationship to Patient	Effective Date	Expiration Date

Secondary Insurance (if applicable)

Name of Insurance Company	Policy #
Name of Policy Holder Policy Holder Date of Birth	Group #
Address of Insurance Company	Copay Amount (specialist)

City, State, Zip	Phone	Deductible
Relationship to Patient	Effective Date	Expiration Date

I hereby authorize payment of insurance benefits directly to the Circle of Life Women's Center. I agree to pay for services not covered by insurance. I understand that payment is due in full within 30 days from my first statement. If it is not paid in full, my account may be referred to Patient Finance & Loan, LLC for financing options. All blood work, pap smears, and cultures are billed through outstide labs. I understand that these charges are separate from the clinic and are generally not included in clinic prices. I realize my information may be shared with outside entities to assist with treatment, research, and/or collection of payment. There will be a $20.00 charge for returned checks. If any legal action is necessary to enforce this agreement, I agree to pay all attorney's fees and court costs in addition of up to a 50% collection fee.

{ } I have current insurance but I choose not to have my insurance billed or use my insurance benefits at this time. I understand that due to certain filing time constraints and pre-authorization requirements, I will be responsible for payment in full for the services rendered. I further release my provider of any obligations under my healthcare plan. **Patient's Initials (only if this option applies):**

My signature indicates I fully understand and agree to the above terms. I further grant authorization for treatment for all evaluations & procedures performed and allow the release of information as indicated above.

Signature **Date**

Rev 02/08/12