PATIENT INFORMATION, DISCLOSURE STATEMENT, & PAYMENT AGREEMENT

All patients are responsible to *Southwest Women's Health Associates f* or charges as billed with payment in full at the time of service.

Patient- Last Name (Mr. Mrs. Ms. Miss. Dr.) | First Name | Middle Name

Patient Street Address | APT. # | City | State | Zip | Home Phone ( )

Patient Mailing Address (If different from above) | E-Mail Address (If available) | Cell Phone ( )

Patient Status (Please circle one) Mar Sing Div Wid Sep | Date of Birth | Age | Sex | Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

Patient's Employeer | May we call you @ work? _____ | Work Phone/ Extension ( ) ext:

Party responsible for payment (For patients under 18) | Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

Responsible party employeer (For patients under 18) | Work Phone/ Extension ( ) ext:

In case of emergency, whom should we notify? | Phone ( )

Relative not living with you- Name | Relationship | Phone ( )

Relatives Address | Apt. # | City | State | Zip

Other Health Care Provider(s)

DISCLOSURE STATEMENT: You are responsible for payment of all charges including resonable attorney fees, all costs of collection and return check charges. All accounts are due and payable in full when the services are rendered. If extended terms are desired on larger balance, our credit manager will be delighted to discuss the matter of a payment schedule that will best suit you. If you have health insurance that will pay for services rendered, please note that you have an additional copy for your insurance billing. You are responsible for payment of this account regardless of any insurance coverage you may have. **I hereby authorize *Southwest Women's Health Associates* to receive payment for services rendered. I also authorize *Southwest Women's Health Associates* to furnish information to any payer for the purpose of claims processing. I hereby acknowledge receipt of this form with full disclosure statement above and I agree to be bound by its terms and conditions.**

Date (1) Date (2)

Date (3) Date (4) Signature of patient or legal guardian