Patient Information

First name: __________________________________ MI: __________ **Last name**: _____________________________

Date of Birth: ___________/___________/_____________ Age: _______________

Race: ___________________________________ Ethnicity: ______________________________

Preferred Language: __________________________ Social Security Number: _________-_________-__________

Street Address: ____ Apt # _______________

City: __________________________________ **State**: ______________ **Zip Code**: ____________________

Home Phone Number: ________-__________-_________ Cell Phone Number: _________-________-__________

Work Number: ________-_________-__________ Email Address: __________________________________

PRIMARY INSURANCE (IF TRICARE - please specify Prime or Standard Active Duty or Retired)
Name of Insurance: ____
Policy/ID #: ____ Group #: _____________________________
Name of the primary holder of this insurance: ____
Patient relationship to the policy holder (check one): Self____________ Spouse___________ Child___________
Date of birth of the policy holder: _____________/______________/_____________
Social Security Number of policy holder: _____________-____________-______________

SECONDARY INSURANCE (IF TRICARE - please specify Prime or Standard Active Duty or Retired)
Name of Insurance: ____
Policy/ID #: ____ Group #: _____________________________
Name of the primary holder of this insurance: ____
Patient relationship to the policy holder (check one): Self____________ Spouse___________ Child___________
Date of birth of the policy holder: _____________/______________/_____________
Social Security Number of policy holder: _____________-____________-______________

Please read the terms and conditions below:

- All Copay, Deductible and Coinsurance amounts are collectible and are expected to be paid at the time services are rendered.
- I understand that any balance after insurance approves or denies payment is my responsibility to pay, including unpaid amounts by a secondary or supplemental insurance.
- After 90 days, all unpaid accounts will be sent to a collection agency for settlement. After an account has gone to collection, additional fees will apply.
- Failure to abide by this financial agreement can/may result in rescheduling of services and/or termination from the practice.
- After two or more missed appointments without 24 hour notice of cancellation may result in no show fees and/or termination from the practice.

*By signing below, I consent to reading, understanding and agree to all of the terms and conditions of this agreement, acknowledge that all of the above information is correct, and give the Women's Health Center of Clarksville permission to file my personal insurance. I also understand that it is my responsibility for knowing and understanding my personal insurance policy and benefits.

Notice of Privacy Practices

* I acknowledge that I have received a copy of the Women's Health Center of Clarksville Notice of Privacy Practices (see attached).

Print Name: ____
Signature: ____ Date: ____________________
Signature of Parent/Guardian if patient is a minor: ____________________________________ Date: _______________