PATIENT INFORMATION

Life Circle WOMEN'S HEALTHCARE

DATE: _____ ***PLEASE USE BLACK INK*** CHART#: _____

PATIENT INFORMATION

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Living Together

Last Name: _____ First Name: _____ M.I. _____ Gender: ☐ M ☐ F

Social Security#_____ D.O.B.: _____ Age: ____ Email (print) _____

Address: _____ City:_____ State: _____ Zip: _____

Home #: _____ Cell #: _____ ****Please Mark Which is the Best # to Reach You****

Name of Employer: _____ Phone #: _____

SPOUSE INFORMATION: or Responsible Party (if different from patient)

Last Name: _____ First Name: _____ M.I. _____ Gender: ☐ M ☐ F

Social Security #: _____ D.O.B.: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Name of Employer: _____

POLICY HOLDER: (if different from patient)

Last Name: _____ First Name: _____ M.I. _____ Gender: ☐ M ☐ F

Social Security #: _____ D.O.B.: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Name of Employer :_____

Emergency Contact: (No access to confidential information)

Name: _____ Phone: _____

Authorized Persons: Patient authorizes **LifeCircle** to provide **confidential information** regarding my health care to the following persons: (If patient is a minor, please include parent/guardian.)

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

*****Please Complete The Other Side*****

The Following Is Information Needed For Electronic Health Records. Please Check All That Apply:

RACE: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Please Check Preferred Method of Contact... ☐ Call or ☐ Text

May we leave messages on preferred phone number? ☐ Yes ☐ No

Your Pharmacy: _____ Address (street,city): _____

Primary Care Doctor: _____

ASSIGNMENT OF BENEFITS / AUTHORIZATION OF TREATMENT & OFFICE POLICIES:

I hereby authorize treatment and authorize LifeCircle Women's Healthcare, PC to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the Provider on my behalf, or to myself. I understand that to knowingly provide invalid insurance information is fraudulent and will result in ALL fees becoming my responsibility, not the responsibility of any insurance I may have at the time of service. I understand that I am responsible for paying any collection costs and attorney fees if this account is turned over to collections. LifeCircle accepts cash, checks, Health Savings Account cards, and major credit cards.

Insurance is a contract between the patient and/or employer and the insurance company. It is NOT a contract between LifeCircle and the patient's insurance carrier. Therefore, I understand that the responsibility for payment belongs to the patient. I understand that it is my responsibility to pay any deductible amount, co-pays, or any other balance not paid by my insurance company at the time of my visit.

On managed care contracts, it is the patient's responsibility to obtain a referral on every visit and to pay any co-pays and deductibles on the day of service. The patient must obtain the referral before her appointment, or she will be asked to reschedule the appointment until the referral is obtained.

No-Show, Cancellation, and Late Policy:

- If a patient needs to cancel or reschedule an appointment, the patient must contact LifeCircle 24 hours in advance.
- If a patient is more than 15 minutes late, we reserve the right to reschedule the appointment.
- A patient who misses a scheduled appointment without calling us in advance will be charged a fee of $25 each time an appointment is missed. A patient that misses appointments 3 times in a calendar year is subject to dismissal from the practice.

I have read, understand, and agree to the above policies for this office. I hereby assign to LifeCircle Women's Healthcare any medical reimbursement benefits under my insurance policy. I authorize the release of any information acquired during the course of my treatment to my insurance company and to other medical providers to which I may be referred for treatment. I acknowledge that I have received the notice of LifeCircle's ***"HIPAA NOTICE OF PRIVACY PRACTICES"***

I give LifeCircle my consent to verify what other medications I am on to minimize conflict of care. If I have listed a Pharmacy on this form, then I give LifeCircle my consent to send my prescriptions electronically to my pharmacy.

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____

TODAY'S DATE: _____ Responsible Party's Relationship To Patient: _____

** We are required by law to maintain the privacy of our patients, and to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.**

LifeCircle
WOMEN'S HEALTHCARE