PATIENT INFORMATION

Last Name:	First Name:	Middle In:	
Address:	City:	State:	Zip Code:
Home #:	Cell #:	Social Security #(Required):	

DOB: / Age:	Preferred Language:	☐ Female ☐ Male	Race:	Ethnicity:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer:	Employer Address:
Email Address:	How did you hear about us? If a patient referred you, Please provide name:
Referring Physician & Phone:	Primary Care Physician & Phone:

Pharmacy Information

Whenever possible, Rappahannock Women's Health Center, P.C. will electronically transmit your prescription(s) Directly

Pharmacy Name & Location:	Pharmacy Phone Number:

INSURANCE INFORMATION

(PLEASE COMPLETE ALL SECTIONS)

Name of Primary Insurance:		Name of Secondary Insurance:	
Subscriber Name:	Relationship to Patient:	Subscriber Name:	Relationship to Patient:
ID#:	Group #:	ID#:	Group #:
Subscriber DOB:	Subscriber SSN:	Subscriber DOB:	Subscriber SSN:

EMERGENCY CONTACT INFORMATION

Last Name:	First Name:	Relationship To Patient:	
Address:	City:	State:	Zip Code:
Home #:	Cell #:	Work #:	

Release of Information to Insurance: I hereby authorize DR. H JAE KIL, DR. MARY SHUMAN, DR. LESLIE MEYER, DR. MICHAEL SMITH, DR. KRISTIN ESPOSITO, DR. PETER PYATAK, DANA TAYLOR, C.N.M. and JULIE WEATHERS C.N.M. To furnish information to insurance carriers concerning my illness and treatments. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENT OR I REMAIN A PATIENT.

Assignment of Insurance Benefits: I, the undersigned, certify that I (or my dependent) have insurance coverage as stated above hereby assign/ authorize payment to this practice, Rappahannock Women's Health Center, P.C. for all insurance benefits, if any, otherwise payable to me for healthcare services provided to the client/patient/dependant at this practice, to be paid directly to the practice. I authorize the use of this signature on all submissions. I understand that if health insurance information is provided, this in no way relieves me of financial responsibility for services rendered now or in the future at this practice. I understand that any lab work performed will be billed by the lab itself

Guarantee of Payment: I understand that I am financially responsible for all amounts payable with regards to fees for healthcare services rendered now and in the future by this practice. In the event of non-payment by me of any amount due to this practice after 45 days, I agree to that in addition to the original amount due, I am fully responsible to pay 18% interest per annum on all collection fees of 33 & 1/3% of the amount due, court cost and reasonable attorney's fees incurred by this practice if required to collect my debt owed.

PATIENT INFORMATION

Signature of Responsible Party:	**Date:**