



Patient Information

First name: _____ MI: _____ Last name: _____

Date of Birth (mm/dd/yyyy): _____ / _____ / _____ Age: _____

Race: _____ Ethnicity: _____

Preferred Language: _____ Social Security Number: _____ - _____ - _____

Street Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ - _____ - _____ Cell Phone Number: _____ - _____ - _____

Work Number: _____ - _____ - _____ Email: _____

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.
- 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: _____