THE WOMEN'S HEALTH TEAM
P.DOUGLAS MUMFREY, M.D. JULIE A. GRIMES, M.D.

Please complete entire form.

Name: _____
LAST FIRST MIDDLE
Home Address: _____
City: _____ State: _____ Zip: _____
SS#: _____Age_____ DOB: _____ Gender: M F Marital Status: M S W D
Telephone: ( ) _____ Cell: ( ) _____
Email Address: _____ May we send information here? Yes No

Occupation: _____
Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: ( ) _____ Ext: _____
May we contact you at work? Yes ____ No ____

Name of Spouse: _____Spouse DOB: _____Age: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____ SS#: _____
Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Employer's Telephone: ( ) _____

In case of emergency, contact: _____ Relationship: _____
Home Phone: ( ) _____ Work Phone: ( ) _____

Primary Care Physician _____ Phone: ( ) _____
Preferred Pharmacy? _____ Location: _____
How did you learn about our practice? _____

Please check which method you prefer that we use as a means to contact you regarding appointment reminders, lab results and other information?
Home # _____ Work # _____ Cell # _____ E-mail address _____

Method of Payment for Today's Visit: ____Cash _____Check ____Credit Card

*** Please present your insurance card(s) and driver's license to the front desk so that we may make a copy of them. Thank you.

Signature _____

Date _____

THE WOMEN'S HEALTH TEAM
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Insurance Information

Patient's Name _____
Last First Middle
Name of Primary Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

Group Number: _____ Policy ID Number: _____
Effective date of policy: _____
Insured's Name: _____ Insured SS# _____
Insured's DOB: _____ Relationship _____
Insured's Employer: _____
Do you have a secondary insurance? _____

FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Necessary forms will be completed to file for insurance carrier payments.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to THE WOMEN'S HEALTH TEAM for medical services rendered to myself and/or my dependents regardless of my insurance benefits.
I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize P. Douglas Mumfrey, M.D. or Julie A. Grimes, M.D. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from P. Douglas Mumfrey, M.D. or Julie A. Grimes, M.D. on behalf of myself and/or my dependents and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Signature of Patient or Responsible Party: _____

Date: _____