Women's Specialty & Fertility Center

DATE_____ CHART#_____

PRIMARY CARE PHYSICIAN_____

OB/GYN(Fertility pts only)_____

REFERRED BY_____

PATIENT INFORMATION_____
(LASTNAME) (FIRSTNAME) (MIDDLE INITIAL)

☐ MARRIED ☐SINGLE ☐WIDOWED

☐ SEPARATED☐DIVORCED HOMEPHONE(____)_____ ☐ CELL # (____)_____

SOC. SEC.#_____ BIRTHDATE____/____/____ AGE_____

ADDRESS_____

CITY_____STATE_____ZIP_____

EMPLOYER_____CITY_____

WORK PHONE(_____)_____

SPOUSE/SIGNIFICANT OTHER _____
(LASTNAME) (FIRSTNAME) (MIDDLE INITIAL)

SOC. SEC.#_____ BIRTHDATE____/____/____ AGE_____

EMPLOYER_____CELL PHONE(____)_____

IN CASE OF EMERGENCY *PLEASE NOTIFY (Name of someone not living with you)*

NAME_____PHONE(_____)_____

DO YOU HAVE MEDICAL INSURANCE? ☐YES ☐NO
IF YES, WHO IS THE INSURANCE THROUGH? ☐SELF ☐ SPOUSE ☐PARENT

PrimaryInsurance

Insur. Name_____

Subscriber_____

Policy#_____

Group#_____

Ins Address_____

Ins Phone#_____

Secondary Insurance

Insur. Name_____

Subscriber_____

Policy#_____

Group#_____

Ins Address_____

Ins Phone#_____

ASSIGNMENT OF INSURANCE BENEFITS

CONSENT TO OBTAIN INFORMATION AND IRREVOCABLE ASSIGNMENT OF BENEFITS: THE UNDERSIGNED HEREBY AUTHORIZES THE PHYSICIAN, HIS/HER AGENTS OR REPRESENTATIVES, TO VERIFY ELIGIBILITY OF MEDICARE COVERAGE, TITLE XVIII OF THE SOCIAL SECURITY ADMINISTRATION AND/OR MEDI-CAL, TITLE XIX OF THE WELFARE AND INSTITUTIONS CODE. THIS AUTHORIZATION AND CONSENT ALSO APPLIES TO ANY OTHER THIRD PARTY PAYER AS DETERMINED TO PROVIDE MEDICAL EXPENSE COVERAGE ON MY BEHALF INCLUDING HEALTH INSURANCE COVERAGE. I HEREBY IRREVOCABLY ASSIGN TO THE PHYSICIAN, TO THE EXTENT PERMITTED BY LAW, ALL RIGHTS AND BENEFITS PAYABLE ON MY BEHALF FROM ANY ABOVE MENTIONED COVERAGE PROGRAM(S). I FURTHER UNDERSTAND THAT I AM PRIMARILY RESPONSIBLE FOR ALL PHYSICIAN CHARGES REGARDLESS OF ANY ASSIGNMENT OF BENEFITS. IF THE INSURANCE DENIES COVERAGE OR DOES NOT PAY IN A REASONABLE TIME, I AGREE TO MAKE SATISFACTORY ARRANGEMENTS TO SETTLE THE ACCOUNT WITH THE PHYSICIAN AT THE PHYSICIAN'S REQUEST. I FURTHER ACKNOWLEDGE THAT ANY PAYABLE BENEFITS, WHEN RECEIVED BY THE PHYSICIAN, WILL BE CREDITED TO MY ACCOUNT, ACCORDING TO THE ABOVE ASSIGNMENT. THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READS THE FOREGOING, RECEIVED A COPY THEREOF, AND IS THE PATIENT, THE PATIENT'S LEGAL REPRESENTATIVE, OR IS DULY AUTHORIZED BY THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

FINANCIAL DISCLOSURE

WOMEN'S SPECIALTY AND FERTILITY CENTER (WSFC) IS A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP (CFMG) AND I MAY RECEIVE A BILL FROM CFMG FOR SERVICES PROVIDED BY WSFC AND/OR THE GROUP'S PROVIDERS.

_____ _____
PATIENT/PARENT/GUARDIAN/CONSERVATOR DATE

_____ _____
IFOTHERTHANPATIENT,INDICATERELATIONSHIP WITNESS