

Date \_\_\_\_\_

**Patient Information**

Patient Name (Last) _____ (First) _____ (MI) _____			Patient Birthday _____
Address _____			Social Security Number _____
City _____	State _____	ZIP _____	Sex <b>M F</b> Marital Status <b>S M D W</b>
Home Phone _____	Work Phone _____	Cell Phone _____	E-mail Address _____
Patient Employer _____	Phone _____	Family Doctor _____	
Employer Address _____			Gynecologist _____
City _____	State _____	ZIP _____	Referred by _____

**Policy Holder**

Name of Policy Holder, If Different from Patient (Last, Middle, First) _____			Relationship to Patient _____
Address _____			Birthdate _____
City _____	State _____	ZIP _____	Social Security Number _____
Home Phone _____	Work Phone _____		
Employer _____	Phone _____		
Who is financially responsible for payment? _____			
Emergency Contact Name _____		Emergency Contact Phone _____	

Primary Insurance claims will be filed on your behalf with correct insurance information. Please provide our office with a copy (front and back) of your insurance card. Supplementary/Secondary carriers are filed ONLY for Medicare patients.

All HMO/POS patients must bring a referral from their Primary Care Physician. If you do not bring your referral, you will be expected to pay in full at the time services are rendered.

**Assignment and Release:**

I hereby consent for The Center for Advanced Breast Care, S.C. to provide me with medical treatment. I authorize the release of medical information contained in my chart to my, and/or, the insured's insurance company in order to process any bills. I authorize the use and disclosure of my private health information for the purpose of: Treatment, Payment, and Healthcare Operations. I authorize payment from my, and/or, the insured's insurance company directly to The Center for Advanced Breast Care, S.C. Should my insurance company deny or not cover charges for ANY reason, I am financially responsible for the full amount of the bill.

Should my account be referred to an outside collection agency, I agree to pay the collection fees should I decide to return to this office.

Signature of Patient (or Personal Representative if patient is a minor) \_\_\_\_\_ Today's Date \_\_\_\_\_