Computer Number

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WOMAN'S CLINIC
Clarksdale, Mississippi

Medical Record
Information
PLEASE PRINT

PATIENT INFORMATION:

Date: ______________

Patient's Name ______________

Address ______________

______________ Cell Phone ______________

Sex ______________ Date of Birth ______________ Age ______________ Home Phone ______________

Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Sep Social Security # ______________

Employer ______________ Work Phone ______________

Employer's Address ______________

Drug Allergies ______________

Pharmacy of Choice ______________ Telephone ______________

Spouse's Name ______________ Social Security # ______________

Spouse's Date of Birth ______________

Spouse's Employer ______________ Emp. Work # ______________

In An Emergency Call ______________

NEW PATIENT ONLY

How did you find out about Woman's Clinic?

☐ Advertisement ☐ Other / Explain ______________

PATIENT'S NEAREST RELATIVE: ______________ Relationship ______________

Address ______________ Telephone ______________

PERSON RESPONSIBLE FOR BILL:

Guarantor's Name ______________

Address ______________

City ______________ State ______________ Zip ______________

Social Security # ______________ Home Phone ______________

Employer ______________ Work Phone ______________

Employer's Address ______________

INSURANCE INFORMATION:

Primary Insurance Company ______________

Address ______________

Verification of Insurance Telephone Number: ______________

Insured Name ______________ Relationship ______________

Policy Number ______________ Group Number ______________

Secondary Insurance Company ______________

Address ______________

Verification of Insurance Telephone Number: ______________

Insured Name ______________ Relationship ______________

Policy Number ______________ Group Number ______________

PLEASE READ AND SIGN THE BACK SIDE OF THIS PAGE

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I AUTHORIZE Woman's Clinic and staff to perform medical treatment.

I AUTHORIZE any physician, medical practitioner, hospital, clinic or other medical or medically related facility, peer review organization, Insurance or reinsuring company, the Healthcare Financing Administration, the Medical Information Bureau, Inc. consumer reporting agency, employer or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, and/or Acquired Immunodeficiency Syndrome (AIDS) and/or tests for or infection with Human Immunodeficiency Virus (HIV), and /or treatment of me or my dependents to give to the group policyholder, my employer, third administrator, my third party carrier of its legal representative, and all such Information.

I UNDERSTAND the information obtained by this authorization will be used to determine eligibility for insurance, and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

It is understood that all hospitalizations, both emergencies and routine admissions are at NWMRMC in Clarksdale.

Please be advised that your medical history is strictly confidential. Absolutely NO information will be released without proper legal consent, unless so deemed by laws of this state.

PAYMENT OF BENEFITS

I AUTHORIZE that payment of medical benefits be made to Woman's Clinic on any claim submitted for any services furnished me by that Woman's Clinic and staff.

I UNDERSTAND that any money received from the above named insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I further agree in the event of nonpayment, to bear the cost of collection, and/or Court cost and reasonable legal fees should this be required.

I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I UNDERSTAND that I am financially responsible to Woman's Clinic for charges not covered by this authorization and for any portion of charges not covered by this authorization and for any portion of charges for my care not covered by my insurance.

Patient's Signature:______________________________ Date:______________

Insured or Guardian's Signature:______________________________ Date:______________

STATEMENT TO PERMIT PAYMENT TO MEDICAID BENEFITS TO PROVIDER

Medicaid Recipient's Name:____

Medicaid I.D. Number:____

I request that payment of authorized Medicaid benefits be made on my behalf to The Woman's Clinic.
I authorize any holder of medical or other information about me to release it to the Division of Medicaid or the Fiscal Agent any information needed to determine these benefits payable for related services.

*** This Authorization Is Good for My Lifetime ***

Recipient's Signature:______________________________ Date:______________