LAST NAME

FIRST NAME

M.I.
SSN #

PATIENT INFORMATION

MEDICAL INSURANCE:

- -

BIRTH DATE (mm/dd/yyyy)

/ /

AGE
MARITAL STATUS

Single Married Separated Divorced Widowed

CURRENT STREET ADDRESS

CITY

STATE
ZIP
(1) PRIMARY PHONE #

( )

(2) WORK/ALTERNATE PHONE #

( )

BILLING ADDRESS (IF DIFFERENT FROM ABOVE)
CITY

STATE
ZIP

CONTACT INFORMATION:

PATIENT'S EMPLOYER

CURRENTLY WORKING? YES NO
OCCUPATION/POSITION:
ARE YOU A STUDENT?
YES NO
WORK ADDRESS

CITY

STATE

PHONE #

( )

IN CASE OF EMERGENCY, NOTIFY

RELATIONSHIP
PHONE #

( )

PRIMARY INSURANCE

ADDRESS
CITY
STATE
ZIP
POLICY/ID #

GROUP #

INSURANCE PHONE #

( )

POLICY HOLDER NAME

BIRTH DATE (mm/dd/yyyy)

SSN #
RELATIONSHIP TO PATIENT
POLICY HOLDER'S EMPLOYER

CITY / STATE
PHONE #

( )

PLEASE READ AND INITIAL

May A Woman's Healing Center leave a message regarding your lab results and/or details of any necessary appointments on your answering machine?

(please check box AND initial on line)

YES _______________ NO _______________

***PREFERRED PHONE NUMBER FOR RESULTS: ____

INSURANCE ASSIGNMENT / PATIENT FINANCIAL RESPONSIBILITY

I request that payment under my insurance plan be made to A Woman's Healing Center, LLC (AWHC) for all services/charges furnished to me by AWHC. I agree to be responsible for payment of all services/charges rendered by AWHC to me. I also authorize AWHC to release to my insurance company or its agents, information for any insurance claim. I also permit a copy of this authorization to be used in place of the original. In the event of nonpayment or underpayment of any charges/services by my insurance company, I understand and agree to be responsible for those charges, including a fee of 1 ½ % per month on my unpaid balance. I agree to submit a binding arbitration with AWHC (the arbitrator to be selected by AWHC), to be held in Fort Collins, CO regarding my dispute or collection concerning my account in lieu of court proceedings. The Colorado Uniform Arbitration Act shall apply to all such disputes, with the exception that AWHC shall select the arbitrator. I agree to pay for all arbitration costs as well as all fees charged for time spent by any and all of AWHC representatives and witnesses, to be billed at $300 per hour pursuing any such dispute or collection matter. The arbitrator's decision shall be additional binding judgment to be entered in a Larimer County Colorado Court.

By my signature below, I acknowledge reading and agreeing to the above terms.

____ ____________________

PATIENT'S SIGNATURE Date

A Woman's Healing Center, LLC

Comprehensive Care in Obstetrics and Gynecology

Christine Skorberg, MD