A WOMAN'S HEALING CENTER, LLC
Obstetrics Gynecology Aesthetics

Patient Information

Last Name_____First Name_____MI_____SS#_____

Birth Date (mm/dd/yyyy) / / / Age_____

Marital Status: _____Single
_____Married_____Separated_____Divorced_____Widowed

Current Street Address_____
____

City_____ State_____
ZIP_____

Billing Address (if different from above)

Street Address_____
_____

City_____ State_____
ZIP_____

Telephone: Primary ( )_____
Cell( )_____
Work/Alternative ( )_____

Your email address_____
_____
(On occasion, we send health advisories, notifications, newsletters, and invitations. We never sell email addresses, and strictly limit their use to communications from the practice. May we add you to our email list? ___Yes ___No)

How did you learn about our office?

_____Doctor _____Patient _____Website _____Social Media
_____Family
Other (please
specify)_____
___

Whom may we thank for the referral?
_____

Contact Information

Are you currently working? ___Yes ___No
Occupation_____
Patient's
Employer_____
_____
Work
Address_____
_____
City_____ State_____Phone
( )_____
Are you a student? ___Yes ___No
In case of emergency,
notify:_____
Relationship_____ Phone
( )_____
Medical Insurance

Primary Insurance_____
Address_____
City_____
State_____ ZIP_____
Policy/ID#_____
Group#_____
Insurance phone
number( )_____
Policy holder's name_____ Birth
date_____
Policy holder's 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 phone or other answering device?

Yes_____ Initials_____ No_____ Initials_____

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 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 1.5 percent 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, Colorado, regarding my dispute or collection concerning any amount 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 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