

South Texas Women's Health Center, PA

Dr. Juan Carlos Rivera

Patient Information Form

Patient's Name _____
Last First Middle

Address _____
City State Zip Code

Phone numbers: _____
Home Work Cell

Social Security # _____ Date of Birth _____ Age _____

Employer _____ Address _____

Referred By _____

Spouse Information

Name _____ Date of Birth _____ SS# _____

Employer _____ Work Number _____

Name of two emergency contacts other than spouse (Friends or Relatives)

1. Name _____ Relation to patient _____

Phone Numbers: Home _____ Work _____ Cell _____

2. Name _____ Relation _____

Phone Numbers: Home _____ Work _____ Cell _____

Insurance Information

Insurance Name & Address _____

Policy Holder's Name _____ Relation to Patient _____

Policy # _____ Group# _____ DOB _____

Consents

Insurance authorization: I hereby authorize South Texas Women's Health Center, PA, to provide information to my insurance carrier concerning by illness and treatment.

Assignment of Benefits: I authorize my insurance benefits to be paid directly to the physician and/or South Texas Women's Health Center, PA. I understand that I am financially responsible for any balance not paid by my insurance. I also authorize the employee's of South Texas Women's Health Center or my insurance carrier to release any information required to process my claim.

Patient's Signature

Date

Welcome to
South Texas Women's Health Center, P.A.
Dr. Juan Carlos Rivera

The goal of this practice is to provide patients with excellent medical care in a friendly, caring atmosphere. To better assist you and ensure prompt payment by your insurance carrier, we will make a copy of the following:

1. Insurance Card
2. Driver License Photo ID
3. Social Security Card

Payment for Services: Full Payment is expected at time of service unless prior financial arrangements have been made with our office manager. For your convenience, we accept cash, personal checks, and or credit cards.

As a courtesy, we will be glad to file your insurance claims. Any deductible, co-payment, and/or co-insurance must be paid at time of service. Please provide us with accurate and updated information regarding any changes regarding your insurance carrier, address, employment and telephone numbers.

Services Rendered to Minors: Patients under the age of 18 who are not pregnant will need to be accompanied by an adult. The adult will be responsible for payment of services rendered.

No Children Allowed: In consideration of our limited sitting space, for the comfort of other patients and to protect our OB patients from contracting illnesses, we ask that you do not bring your children on your appointment. If you bring your children we will need to reschedule you.

In order to provide the best possible service and availability to all our patients, we ask that all appointments which need to be cancelled be cancelled 24 hours prior to scheduled appointment. Failure to cancel 24 hours prior to appointment will result in a \$25.00 charge.

FEES FOR SERVICES:

- \$25.00.....Copies of medical records, from 1 to 20 pages and .25 for each additional page
- \$20.00.....Insurance disability forms
- \$10.00.....Copies of yearly statements
- \$ 1.00.....Copies of labs or encounter forms

No Food or Drinks: In order to keep our waiting area clean for you we ask that you do not bring food or drinks.

Your satisfaction is very important to us. We appreciate your trust and confidence in choosing **South Texas Women's Center** for your medical care. Please address any questions, suggestions, or concerns regarding fees or services to our office manager.

I have read and understand the policies of the practice. I agree to abide by its terms. I also understand that such terms may be amended from time to time by the practice.

Signature of Patient and/or Responsible Party

Date