

Women's Medical Care of Hudson Valley, P.C.

Patient Information:

Patient's Name: _____ Age: _____ Chart #: _____
Address: _____ DOB: _____ LMP: _____
_____ SSN: _____ S M D W
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Women's Medical Care Doctor: _____ Primary Care Doctor: _____
Pharmacy Name: _____ Phone #: _____
Patient's Employer: _____ Occupation: _____
Address: _____

Spouse/Parent Information:

Name: _____ DOB: _____ SSN: _____
Employer: _____ Occupation: _____
Address: _____ Work Phone: _____

Insurance Information:

Primary: Insurance Name: _____ Policy #: _____
Group/Plan #: _____ **Insured:** Self Spouse Parent
Secondary: Insurance Name: _____ Policy #: _____
Group/Plan#: _____ **Insured:** Self Spouse Parent
Tertiary: Insurance Name: _____ Policy #: _____
Group/Plan#: _____ **Insured:** Self Spouse Parent

Emergency Contact:

Name: _____ Phone #: _____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits to Women's Medical Care of Hudson Valley, P.C. including major medical benefits to which I am entitled, Medicare, private insurance and any other plan.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assigned to release all information necessary to secure the payment.

A service chare of 1 1/2 % per month will be added to all accounts no paid within thirty days. In the event this account is assigned to collection, I agree to pay all costs of collection including reasonable attorney fees.

SIGNED: _____

DATE: _____