NEW PATIENT ENROLLMENT FORM   Date __________

Last name ____

First name ______________________________ Middle initial __________

Address ____

City ________________ State ____________ Zip __________________

Home phone ___________________ Cell phone _____________________

Email Address ____

Can we leave a message at any of these numbers? ______________________

Work phone _________________ Primary Care Doctor __________________

Social Security Number ___________________ Date of Birth ____________

Marital Status: single married divorced legally separated widowed

Emergency Contact ___________________ Phone____________________

Relationship________________________

Smoker? Y N Pregnant? Y N Do you have an Advanced Directive, Living Will or Medical Power of Attorney?______________________________

Insurance Company name _______________________________________

Claims mailing address____

City______________________ State _________ Zip _______________

Customer Service phone number __________________________________

Policy ID# ________________________ Group #_____________________

Insured name _______________________ Date of Birth _______________

Employer __________________________ Relationship to insured _________

SONORA WOMEN'S HEALTHCARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _______________________________________ acknowledge that I have received a copy of

(Name of Patient)

'Notice of Patient Privacy Practices'. This Notice describes how SONORA WOMEN'S HEALTHCARE may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

_______________________________________ _______________

(Signature of Patient, or Personal Representative) (Date)

____

(Relationship to Patient)

SONORA WOMEN'S HEALTHCARE

OFFICE POLICY ON MANAGED CARE INSURERS

In order to accommodate the needs and requests of or patients, we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of each plan. Each one has different stipulations regarding how often services may be rendered, and, even more importantly, where those services may be performed. Depending on what type of contract your employer has agreed to we find differences even within the same insurance plans.

Providing quality care for our patients is our primary concern. We are more than willing to provide care within your insurance limitations.

If we are uninformed by you of any special requirements in your personal insurance contract we cannot be responsible for charges incurred by you for services we have ordered. Payments for these services become your responsibility.

It is our office policy to collect copays prior to service. If you unable to pay your copay, we will need to reschedule your appointment.

With your cooperation and help, you should be able to receive all benefits offered to you, and we will be able to concentrate on caring for your medical needs.

****

______________________________ Patient Signature

______________________________ Date

______________________________ Witness

______________________________ Date

SONORA WOMEN'S HEALTHCARE

PAYMENT AND INSURANCE POLICY

In order to acquaint our patients with our policies regarding payment of services, we have prepared this explanatory statement. Please feel free to discuss any questions you may have with our front office administrator prior to your appointment.

The patient is ultimately responsible for **all charges** incurred. Our business office will provide the services of billing your medical insurance company, however, you, as the patient, are responsible for providing us with all of the **correct** and **complete** information regarding you insurance company and coverage. **It is your responsibility to be aware of your insurance benefits. This includes knowing your copay amount, your deductible, coinsurance and any non-covered services.**

If we do not receive any response from your insurance company after 45 days from the day we sent the claim the charges will automatically be billed to you. It is the **patient's responsibility** to contact her insurance company to resolve the matter of non payment.

If your deductible has not been met, you have a copay, coinsurance, or do not have medical coverage for your visit; PAYMENT **IS DUE AT THE TIME OF SERVICE**. Per our office policy we accept cash, Visa, Mastercard, and Discover Card as forms of payment. **Personal checks are not accepted**.

The patient is always responsible for providing our office with any new insurance information, including any changes to your current policy.

If the patient account balance is over 90 days old without a payment on the account, the account is then turned over to an outside collection agency. If you receive a statement and have any questions, please contact us at (602)-710-2030 and we will help you to understand your balance. **PLEASE DO NOT IGNORE ANY STATEMENTS SENT TO YOU.** If your account is turned over to collections, the collection agency will add a **collection fee of 35%.**

If for any reason you decide to discontinue care with our office and have a credit balance on your account we will assess a **$50.00** fee to process and issue a refund check to you.

If you have any questions concerning your account or an insurance claim please call us and we will be happy to help you.

______________________________	______________________________
Please Print Name	date
Patient Signature/Legal Guardian	relationship to patient
Witness	date