HENDERSON & WALTON WOMEN'S CENTER, P.C.

Office Location: Select One

Physician: Select One

For Office Use Only Dr. _____

Date | N | R | C | Account Number

Patient Information

Last Name	First	Middle		
Your Billing Address	City	State	ZIP	
Street address	City	State	ZIP	
Birthdate	Social Security#	E-mail		
Occupation	Employer	Driver's License #	State	
Home Telephone #	Work Telephone #	Cell Phone #	Emergency Telephone #/Relationship to Person	
Married ☐ Divorced ☐ Single ☐ Widowed ☐	Pharmacy	Pharmacy Phone	Pharmacy Location	

Insurance Information

Name of Insurance Company		Policy/Contract Number	
Group Number	Effective Date	Subscriber's Name	Relationship/DOB
Additional Insurance		Policy/Contract Number	
Group Number	Effective Date	Subscriber's Name	Relationship/DOB
Primary Care Physician with Ins. Carrier			

How Did You Hear About Us?

Friend	Yellow Pages	Newspaper	Direct Mail	Website	Physician *(name)*

Insured/Spouse/Parent

Name*	* Birthdate	* Social Security #
Employer*		* Work Telephone #
Employer's Address*		

* Required Fields

CONSENT FOR TREATMENT - I hereby authorize the physicians, nurses, and other healthcare providers of Henderson & Walton Women's Center, P.C. ("HWWC") to provide such medical assessment and treatment, including drugs, medications, operations and x-rays and other studies, as they deem appropriate.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize HWWC to furnish any medical information requested by insurance companies with whom I have coverage, any public agency, such as Medicare or Medicaid, if it is assisting in payment of my care, or my employer if it is providing payment of my medical bills due to an on the job injury (each a Third Party Payor).

ASSIGNMENT OF BENEFITS - I hereby assign to HWWC, or its duly authorized agents and/or assigns, all rights, benefits and interest in all proceeds from all Third Party Payors. I authorize payment directly to HWWC of benefits otherwise payable to me for services rendered and further authorize HWWC to take all necessary actions to ensure that any such benefits are paid directly to HWWC. I agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the above purposes. I understand that any amount paid to HWWC in excess of regular charges will be refunded as appropriate.

FINANCIAL RESPONSIBILITY - I acknowledge that I am legally responsible to HWWC for, and I agree to pay to HWWC, all charges not paid in full by a Third Party Payor including, but not limited to, co-payments, deductibles, coinsurance and non-covered charges. Charges remaining on this account are payable upon demand. I hereby waive all claims for exemption, including without limitation exemption from levy or execution, under the laws of the State of Alabama, and if my account is placed in the hands of a collector or attorney for collection or suit, I will pay all reasonable costs of collection fees, including reasonable attorneys fees.

SIGNATURE _____ DATE _____