Women's Health Associates, Inc.

PH: 781-237-0080

2000 Washington Street Suite 760 Green Building
Newton, Ma 02462

Thank you for taking the time to complete this form. We ask that you complete this entire form once a year **or** when you have any **NEW** information.

PATIENT NAME: _____ **DOB:** _____/_____/_____

Single___ Married___ Divorced___ Widowed___ Spouse/Partner Name: _____

Street Address_____ **City/State/Zip** _____

Home (_____) _____-_____ Work (_____) _____-_____ Cell (_____) _____-_____

Emergency Contact Name _____ **Phone (_____) _____-_____**

Patient Employer _____ **Primary Language**_____ **Ethnicity**_____

Primary Care Physician _____ **Phone (____) _____-_____**

Who referred you to us? _____ **Phone (____) _____-_____**

Are we able to leave a voice mail at the numbers you have provided?	**YES**	**NO**
Do you want a chaperone present during your exams?	**YES**	**NO**

PRIMARY INSURANCE INFORMATION

Insurance Company/ Address _____**Policy / Certificate #** _____ **Group #** _____
** MUST BE FILLED
****Policy Holder's Name** _____ **Relationship to patient: Self/ Spouse/ Parent/ Partner**
****Policy Holder's Date of Birth** _____/_____/_____
Policy Holder's Employer _____
Policy Holders address (if different from patient) _____

Secondary Insurance Information

Insurance Company/ Address _____**Policy/certificate#** _____ **Group#** _____
Must be filled in ****Policy Holder's Name**_____ ****Policy Holder's DOB** ____/___/____
Policy Holder's address (if different from patient) _____

Insurance Authorization and Assignment to be signed by ALL PATIENTS

I hereby authorize Women's Health Associates, Inc. to furnish information necessary to the above insurance carriers concerning my illnesses and treatments. I hereby assign WHA,Inc. all payments for medical services rendered without a valid referral that may be required by my HMO, all services provided to me, if at the time of service my insurance carrier does not contract with WHA, Inc. and any amount not covered by my insurance. I have read the office Notice of Privacy Practice according to HIPAA federal regulations and I consent to the use and disclosure of my protected health information to carry out my treatment

Patient/Guardian Signature_____ **Date:** _____

MEDICARE PATIENTS ONLY: MEDICARE AUTHORIZATION AND PAYMENT REQUEST.

I certify that the above information given by me in applying and under Title XVII of the Social Security Act is correct. I authorize Women's Health Associates, Inc. to release any medical information about me to the Social Security Administration or intermediaries or carriers needed for medical claims. I request that payment of authorized benefits be made on my behalf to WHA, Inc. I assign benefits payable to WHA, Inc. for services rendered to me. I have read the office Notice of Privacy Practice according to HIPAA federal regulations and I consent to the use and disclosure of my protected health information to carry out my treatment.

Medicare Patient/ Guardian Signature _____ **Date:** _____