Associates in Women's Health, P.C.

2801 YOUNGFIELD STREET, SUITE 200
GOLDEN, CO 80401
P: 303-940-1867 F: 303-940-1894

Please Circle Your Doctor: **ELLIS GANTER PYTHON SCHOEN WESSELL, WHNP**

PATIENT INFORMATION

Account #		Social Security #:	
Name:		DOB:	
Address:			
City:	State:	Zip:	
Race:	Ethnicity: (**Please circle**)	Hispanic/Latino	NOT Hispanic/Latino
Marital Status:	Spouse's Name:		

Please circle your preferred telephone number .

Home Phone:
Work Phone:
Cell Phone:

IF WE MAY LEAVE RESULTS ON YOUR PREFERRED NUMBER'S VOICEMAIL, INITIAL HERE: _____

PHARMACY PHONE #:
E-MAIL:

Responsible Party (Guarantor) Info

Name:		
Billing Address:		
City:	State:	Zip:
Phone:		

Insurance Information

Primary Insurance Carrier:	
Insurance Claims Address:	
Insurance Claims Address Cont:	
Subscriber**:**	Employer:
Subscriber DOB:	Employer Phone #:
Subscriber Sex:	
Subsciber SSN:	
Relationship to Subscriber:	
ID #:	
Group # (if applicable):	

Secondary Insurance Carrier:	
Insurance Claims Address:	
Insurance Claims Address Cont:	
Subscriber**:**	Employer:
Subscriber DOB:	Employer Phone #:
Subscriber Sex:	
Subsciber SSN:	
Relationship to Subscriber:	
ID #:	
Group # (if applicable):	

1) CONSENT TO TREATMENT

I consent to treatment by Associates in Women's Health, PC, provided by and under the care of the physician, her associates, partners, assistants, other staff and/or contracted providers. I consent to outpatient care which encompasses diagnostic examination and procedures including, but not limited to laboratory, medication, drug testing, removal and disposal of tissue, nursing or medical/surgical treatment that my physician, associates, partners, assistants may deem necessary or advisable, under the general and special instructions of the same.

2) NON-DISCRIMINATION POLICY

Associates in Women's Health, PC, will admit and treat patients regardless of race, color, national origin, religion, sex, sexual orientation, marital status, age or disability.

3) ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign my right to and authorize Associates in Women's Health, PC to bill and receive payments directly from my insurance carrier for any benefits or series of benefits covered and payable by my insurance carrier, as well as proceeds of claims resulting from the liability of third party(ies) or organizations. I further understand that prior to receiving services I may choose to pay for services directly. If I do not want my health information for that service to be provided to my insurance carrier or other third party payer.

4) NO SHOW POLICY

Please be courteous of your appointment time and allow <u>24 hour notice</u> to cancel/reschedule your appointment. Failure to do so will result in a no show fee of $50. For one hour procedures, the no show fee is $100 without a <u>72 hour notice</u>,

5) FINANCIAL AGREEMENT

I the undersigned, individually obligate myself to the payment of my Associates in Women's Health, PC account incurred by the patient's service(s). I understand that I will be responsible for charges not covered by my health insurance carrier(s). I will be expected to pay my medical bill in full when I am discharged or at the time of provision of medical services, diagnostic services and/or procedures, unless I have made other arrangements with Associates in Women's Health, PC's financial department. Should these bills not be paid, I understand that my account and any of my healthcare information necessary for collection of the bill, will be referred to an attorney or collection agency. I will be responsible for paying all attorney's fees, court costs, and other legal fees and costs incurred in collecting my medical payment, together with late fees and interest at the maximum rate allowable by law.

DISCLOSURE:

I have read and understand these documents and accept and agree to follow the conditions contained therin. I also understand that certain health information may be released to state and/or other federal agencies for reporting purposes unless otherwise stated below.

X_____ _____

Signature: Patient, Guardian, or Legal Representative* Print: Patient, Guardian, or Legal Representative

_____/_____/_____ **Date**