PLEASE PRINT

PATIENT INFORMATION RECORD

SOCIAL SECURITY # ____________ PHONE NUMBER ____________ DATE ____________

NAME OF PATIENT: ____________ LAST ____________ FIRST ____________ MIDDLE

MAILING ADDRESS: ____________ STREET ____________ CITY ____________ STATE ____________ ZIP

HOME ADDRESS: ____________ STREET ____________ CITY ____________ STATE ____________ ZIP

DATE OF BIRTH: ____________ AGE: ________ SEX: ___ RELIGION: ____________ MARITAL STATUS: ________

EMPLOYER: ____________ PHONE: ____________

ADDRESS: ____________ STREET ____________ CITY ____________ STATE ____________ ZIP

SPOUSE'S NAME: ____________ DOB: ____________ SS#: ____________

EMPLOYER: ____________ PHONE: ____________

PERSON RESPONSIBLE FOR THIS ACCOUNT: ____________

PERSONS WHO CAN ALWAYS CONTACT YOU (OTHER THAN SPOUSE):

____________ NAME ____________ ADDRESS-PHONE ____________ RELATIONSHIP

____________ NAME ____________ ADDRESS-PHONE ____________ RELATIONSHIP

REFERRED BY: ____________

DO YOU HAVE MEDICAL INSURANCE? YES ( ) NO ( ) CERTIFICATE #: ____________

NAME OF INS. COMPANY: ____________ POLICY/GROUP #: ____________

ADDRESS: ____________

PLEASE LIST ALL ALLERGIES TO DRUGS: ____________

I UNDERSTAND THAT A MONTHLY FINANCE CHARGE OF $1\frac{1}{2}$% WILL BE ASSESSED ON ANY BALANCE DUE OVER SIXTY DAYS AND I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY INSURANCE CLAIM:

(SIGNATURE OF PATIENT / LEGAL GUARDIAN) ____________

IF PATIENT IS A MINOR OR STUDENT:

FATHER'S NAME: ____________ HOME PHONE: ____________

HOME ADDRESS: ____________ CITY: ____________ STATE: ____________

FATHER'S EMPLOYER: ____________ BUSINESS PHONE: ____________

EMPLOYER'S ADDRESS: ____________ CITY: ____________ STATE: ____________

MOTHER'S NAME: ____________ HOME PHONE: ____________

HOME ADDRESS: ____________ CITY: ____________ STATE: ____________

MOTHER'S EMPLOYER: ____________ BUSINESS PHONE: ____________

EMPLOYER'S ADDRESS: ____________ CITY: ____________ STATE: ____________

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.

FOR THE SAFETY OF OUR OBSTETRIC PATIENTS, CHILDREN UNDER THE AGE OF 12 ARE NOT ALLOWED IN THE WAITING AREA.

ALEXANDRIA WOMEN'S CENTER

ASSIGNMENT OF INSURANCE PROCEEDS AND AUTHORIZATION OF DIRECT PAYMENT

PATIENT: ______________________ SS# / ID#: ______________________

EMPLOYER: ______________________ INSURER: ______________________

I, the aforenamed patient, do hereby assign, convey and transfer any and all rights, claims, or proceeds which I may have under any contract of health insurance, including the aforementioned insurance company, for reimbursement of medical benefits, unto Alexandria Women's Center, 3304 Masonic Drive, Suite 4001, Alexandria, Louisiana 71301.

If my current policy prohibits direct payment or other assignments to a medical provider, then I hereby also instruct and direct my aforementioned insurer to mail such payments to me in care of:

Alexandria Women's Center
3304 Masonic Drive, Suite 4001, Alexandria, Louisiana 71301

I also hereby agree and understand that should the a forenamed insurer not honor this Assignment of insurance Proceeds on any insurance claim made by Alexandria Women's Center, I shall immediately upon receiving such check endorse this check as "Payable to Alexandria Women's Center, and I will further deliver it or mail it to Alexandria Women's Center at 3304 Masonic Drive, Suite 4001, Alexandria, Louisiana 71301.

All payments received by Alexandria Women's Center shall be applied as payment toward the total charges for professional services rendered to me by Alexandria Women's Center, its agents, or employees. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I further understand and agree this if the payments made to the Alexandria Women's Center are insufficient to satisfy the total indebtedness owed by me to the Alexandria Women's Center I do hereby agree, understand and affirm that I will be liable for unpaid balance and will pay in a current manner any amounts remaining due.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I further understand that if I fail to make payment of any balance owed to Alexandria Women's Center in a timely manner, I may be subject to judicial enforcement for any and all claims or amounts owed by me, including attorney's fees, court cost, and interest, as may be allowed by law, resulting from any failure by me to satisfy any amounts owed. I further understand and agree that any unpaid balance will incur interest at the rate of one and one-half ($1^1/_2$) percent per-month on the unpaid balance.

DATED THIS _________ DAY OF ____________________, 20_____.

SIGNATURE OF POLICY HOLDER ______________________

WITNESS ______________________

SIGNATURE OF CLAIMANT (IF OTHER THAN POLICY HOLDER)

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