PLEASE PRINT

PATIENT INFORMATION

_____ _____ _____

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

SPOUSES 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: _____

(SIGNATURE OF PATIENT/LEGAL GUARDIAN): _____

IF PATIENT IF 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 (11/2) 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)

_____