The Center for Womens Healthcare

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Please Print: Date:_____

Name:_____Age:_____Date of Birth:_____Place of Birth:_____

Marital Status:_____TDL Number_____Social Security Number_____Race_____

Home Address_____City_____State_____Zip Code_____Phone_____

Employer_____Occupation_____

Business Address_____City_____State_____Zip Code_____Phone_____

Pharmacy Phone Number_____ Mobile Phone_____Email_____

Medical Allergies_____

Insurance and Billing Information
Person Responsible for Payment (If Other Than Patient)

Name_____Relationship_____

Billing Address_____City_____State_____Zip Code_____

Telephone No. Home_____Work_____

Primary Medical Insurance

Name of Insurance Company_____Telephone No. _____

Name of Policy Holder_____Date of Birth_____Social Security Number_____

Member Identification Number _____Group Number/Name_____

Office Charges: I understand and agree that all services rendered to me by Dr. James Wheeler are charged directly to me and that I am responsible for payment at the time the charges are incurred.
Insurance: After my insurance coverage has been verified, I understand that I will be financially responsible for co-payments, co-insurance, and /or deductible amount at the time charges are incurred and I will remain responsible for my account until insurance payments have been made. Insurance companies pay according to what they set as a negotiated fee or usual and customary. These insurance payments may not always be the same as Dr. Wheeler's charges. If your insurance company on the contract basis for a negotiated fee makes payment, you will only be responsible for co-payments, co-insurance and/or deductible amounts of this fee.
Assignment of Insurance Benefits: I hereby authorize direct payment of surgical/medical benefits to Dr. James Wheeler for service rendered by him in person or under his medical supervision.
Authorization to Release Information: I hereby authorize Dr. James Wheeler to release any medical or incidental information that may be necessary for processing claims for financial benefits.
Insufficient Funds Checks: I understand I will be responsible for a $25.00 service fee for all checks returned by my bank to Dr. James Wheeler's office for insufficient funds.

_____ _____
Patient's Signature (If Under 18 Parent/Guardian) Date Witness Date

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