Patient Information

Name: _____ DOB: _____

Previous Name: _____ Marital Status: _____

Gender: _____ Social Security #: _____ Primary Phone #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Care Provider: _____

Occupation: _____ Employer: _____ Employer Phone #: _____

Spouse/Parent Information

Name: _____DOB: _____

Gender: _____ Social Security #: _____ Primary Phone #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Occupation: _____

Spouse/Parent Employer: _____ Employer Phone #: _____

Insurance Information

(Please provide insurance card at check-in)

Insurance Company: _____ ID #: _____

Group #: _____ Insurance Phone #:_____

In Case of Emergency

Name: _____ Relationship: _____ Phone: _____

Assignment of Benefits and Release of Information

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that:

- I am financially responsible for all charges whether or not paid by my insurance
- I understand that should I default on payment of my account and collection agency services are required, all costs of collections including attorney fees will be added to the balance of my account.

_____

Patient Signature **Date**

ALPINE WOMEN'S CENTER

PATIENT CONSENT, AUTHORIZATION AND RESPONSIBILITY

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.

I authorize the release of any medical and prescription medication information necessary to determine patient care.

I authorize the release of medical information necessary to determine benefits payable for insurance claims for services rendered. I agree that all proceeds of insurance are assigned to this office where applicable.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

I understand my account balance must be paid in full within 90 days of service unless other arrangements have been made with this office.

I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs will be added to the balance of my account.

_____	_____	_____
Printed Name	**Patient Signature**	**SSN**

_____	_____
Date	**Witness**

ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ **DOB**: _____

I hereby authorize Alpine Women's Center to disclose my Protected Health Information (PHI) to the following persons:

Name: _____
Name: _____
Name: _____
Name: _____

- Disclosure may occur in the form of phone conversations, phone messages, mail, or in person. I understand by signing this authorization, above information may include alcohol, drug abuse, mental, and/or other highly confidential information health records obtained in the course of my diagnosis and treatment.
- I give permission to this office to leave phone messages at any phone number I provide this office.
  ☐ Please check box if ok to leave a detailed voicemail message
- I understand that I may revoke this authorization at any time by notifying Alpine Women's Center in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- I understand that once the information described herein is disclosed, it may be re-disclosed by recipient and no longer subject to the privacy protections.

Patient Signature: _____ **Expiration Date**: ___/____/_____

(If left blank, authorization expires twelve (12) months from the date on which it was signed)

Witness: _____ **Date**: _____/_____/_____

ALPINE WOMEN'S CENTER
MEDICATION REFILL POLICY

Our goal at Alpine Women's Center is to assist patients with prescription requests in an efficient manner. In order to process your request as quickly as possible, please allow 48-72 hours for us to process your prescription request. We cannot accommodate any refills after hours, on weekends or on holidays.

Some prescriptions may not be automatically covered by your insurance and may require prior authorization. This process may take up to two weeks.

If you call to request a refill but are overdue for your annual exam and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in enough medication to a local pharmacy to last until we are able to schedule an office visit (up to 4 weeks supply). It is your responsibility to schedule an appointment before you run out of medication.