NORTHWEST WOMEN'S CONSULTANTS, S.C.
CONFIDENTIAL INFORMATION SHEET

Preferred Pharmacy Name _____

PATIENT INFORMATION

Phone ( )_____

Mail Order Pharmacy Name_____

Please Print

Name _____
Last First Middle

☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Address _____
City State Zip

Home Land Line ( )_____ Work Phone ( )_____ Cell Phone ( )_____

Preferred Phone # (choose one) ☐ Home ☐ Work ☐ Cell Email Address _____
Case Sensitive

Race: ☐ Declined ☐ American Indian/Alaskan Native ☐ Asian ☐ African American ☐ Caucasian ☐ Other Race

Ethnicity: ☐ Declined ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Date of Birth _____ Age_____

Emergency Contact

Name: _____ Phone # ( )_____ Relationship_____

OUR POLICY DOES NOT ALLOW US TO CHANGE THE DIAGNOSIS OR SERVICES AFTER THEY HAVE BEEN BILLED TO YOUR INSURANCE COMPANY.

I hereby authorize Northwest Women's Consultants S.C. to furnish information to insurance carriers concerning my illnesses and treatments and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. **I understand that I am responsible for any amount not covered by insurance.**

Confidential Communication

I hereby request Northwest Women's Consultants, S.C., to keep communications regarding my protected health information confidential.

Can we leave a DETAILED message with NORMAL results on answering machine and/or voice mail?

☐ Yes ☐ No

Can we speak to or leave a message with another person? ☐ Yes ☐ No

If yes, with whom? _____

A copy of the Privacy Act is available at the front desk upon request.

If you are treated on or after Jan. 1, 2017 and you have a balance over 90 days old, you will incur a finance charge of 1.5% on the unpaid balance. My signature below acknowledges my financial responsibility.

Signature _____ **Date** _____
(Parent, if minor)