Date :_____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

Women's Health Specialist of Dallas, P.A. reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed a copy of the Notice of Privacy Practices for
Women's Health Specialist of Dallas, P.A.

_____
Name of Patient (Print or Type)

_____
Date of Birth

_____
Signature of Patient

If Patient is a minor:

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Please note that State and Federal Law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.

Secure Phone Option:

Is there a phone number where a message containing personal health information could be left in the event you are not available when we call? **Y** **N**

If 'Yes', what is the number? _ _____

Expanded Authorization Option:
Please list any persons you would like to authorize to have access to your billing, appointment or health information* such as your spouse, caretaker, or other family member:

Name	**Relationship**
_____	_____
_____	_____
_____	_____

*With the exclusion of information that is protected under State and Federal law.

WOMEN'S HEALTH SPECIALISTS OF DALLAS, P.A.

PATIENT INFORMATION
Women's Health Specialists of Dallas, P.A.
*Please print and complete **ALL** sections below!*

Date: _____

PATIENT INFORMATION:

Name: _____ Physician: _____
(Last) (First) (Middle)
Home Address: _____
(Street) (Apt. No.) (City) (State) (Zip Code)
Employer: _____ Occupation: _____
Employer Address: _____
(Street) (City) (State) (Zip Code)
Primary: (_____) _____ Alternate: (_____) _____ Alternate: (_____) _____
Please Circle: HOME MOBILE WORK HOME WORK MOBILE HOME WORK MOBILE
Driver's License No.: _____ Social Security No.: _____-_____-_____ Date of Birth: _____/_____/_____
Marital Status: Single Married Widowed Divorced Age: ____ Allergies: _____
Your E-Mail Address: _____ Home Business

SPOUSE INFORMATION OR RESPONSIBLE PARTY :

Name: _____ SSN: _____-_____-_____ Date of Birth: _____/_____/_____
(Last) (First) (MI)
Address: _____
(Street) (Apt. No.) (City) (State) (Zip Code)
Employer: _____

Primary: (_____) _____ Alternate: (_____) _____ Alternate: (_____) _____
Please Circle: HOME MOBILE WORK HOME WORK MOBILE HOME WORK MOBILE

PHARMACY: _____
Address: _____ Phone: (_____) _____

PRIMARY INSURANCE CARRIER: _____
Name of Primary Card Holder: _____ DOB: _____ SSN: _____
Primary Card Holder Address: _____
Insurance ID No.: _____ Insurance Group No.: _____
Insurance Claim Address: _____

EMERGENCY CONTACT: _____ Relationship: _____
Primary: (_____) _____ Alternate: (_____) _____ Alternate: (_____) _____
Please Circle: HOME MOBILE WORK HOME WORK MOBILE HOME WORK MOBILE

PLEASE BE ADVISED THAT YOU MAY RECEIVE BILLS FOR ANY LAB TESTS, PAP SMEARS, CULTURES, AND BIOPSIES, AS THEY MAY BE SENT TO AN OUTSIDE SOURCE FOR ANALYSIS.

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance to be made directly to Women's Health Specialist of Dallas, P.A. and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ **Your signature:** _____