Northern Colorado Women's Wellness

Patient Information

Last Name_____First Name _____ MI____
SS#_____

Birth Date (mm/dd/yyyy) ____ /_____/_____ Age_____

Marital Status: ___ Single ____ Married ____Separated____Divorced ___Widowed____

Street Address _____

City _____ State _____Zip _____
Billing Address (if different from above) _____

City _____State _____Zip _____

Telephone (primary) _____

Cellular phone _____

Work/alternate _____

Your e-mail address _____

(On occasion, we send health advisories, notifications, newsletters, and invitations. We never sell e-mail addresses and strictly limit their use to communications from the practice.

May we add you to our e-mail list? _____Yes _____No

How did you learn about our office? _____

_____Doctor _____Patient _____Website _____Social Media
_____Family

Whom may we thank for your referral? _____

Contact Information

Are you currently working? _____Yes _____No
Occupation _____

Patient's employer _____

Work Address _____ Phone _____

City _____ State _____Zip _____

Are you a student? _____Yes_____ No

In case of emergency, notify: _____
Relationship to patient _____ Phone (___)_____

Medical Insurance Information: **Please skip if we have copied your medical card**

Primary Insurance_____
Address_____
State_____ZIP_____

Policy/ID#_____
Group#_____
Insurance phone number ( )_____
Policy holder's Birthdate _____
Policy holder's SSN#_____
Relationship to patient_____
Policy holder's employer_____
City_____ State_____
Phone(_____)_____

Please Read and Initial
May Northern Colorado Women's Wellness leave a message regarding your lab results and/or details of any necessary appointments on your phone or other answering device?

Yes_____Initials____ No__Initials___

Preferred phone number for results (___)_____

Insurance Assignment/Patient Financial Responsibility
I request that payment under my insurance plan be made to Northern Colorado Women's Wellness (NCWW) for all services/charges furnished to me by NCWW. I agree to be responsible for payment of all services/charges rendered by NCWW to me. I also authorize AWHC to release to my insurance company or its agents, information for any insurance claim. I also permit a copy of this authorization be used in place of the original. In the event of nonpayment or underpayment of any charges/services by my insurance company, I understand and agree to be responsible for those charges, including a fee of 1.5 percent per month on my unpaid balance. I agree to submit a binding arbitration with AWHC (the arbitrator to be selected by NCWW), to be held in Greeley, Colorado, regarding my dispute or collection concerning any amount in lieu of court proceedings. The Colorado Uniform Arbitration Act shall apply to all such disputes, with the exception that NCWW shall select the arbitrator. I agree to pay for all arbitration costs as well as all fees charged for time spent by any and all NCWW representatives and witnesses, to be billed at $300 per hour pursuing any such dispute or collection matter. The arbitrator's decision shall be additional binding judgment to be entered in a Weld County Colorado Court.

By my signature below, I acknowledge reading and agreeing to the above terms.

Patient's signature _____Date_____