ALTAMONTE WOMEN'S CENTER, P.A.

PERSONAL INFORMATION

In order to serve you properly, please provide the following information. Print clearly and leave no blanks.

NAME _____ DOB _____

ADDRESS_____CITY _____ STATE ___ ZIP _____

HOME PHONE# _____ CELL PHONE # _____

SOCIAL SECURITY # _____

DRUG ALLERGIES _____

EMPLOYER _____ OCCUPATION _____

WORK PHONE# _____ EXT _____

SPOUSE/PARENT NAME _____ OCCUPATION _____

EMPLOYER _____PHONE# _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

HOME PHONE #_____CELL# _____WORK#_____

Do you have Insurance? __Yes ___No If no, how will you be paying today? _____ Cash_____ Check____ C/C

PRIMARY INSURANCE (Insurance companies require the below information for billing purposes.)

Name of Insured: _____Relationship to Pt:_____

Insured's Social Security# ___-____-_____ Insured's DOB: _____

Insurance Co. Name:_____ Phone: ( )_____

Address: _____City: _____State:____Zip_____

POLICY #_____GROUP ID# _____

SECONDARY INSURANCE

Name of Insured: _____Relationship to Pt _____DOB_____

SS#_____-_____-_____Policy #_____Group #_____

Insurance Co. Name:_____ Phone# ( )_____-_____

I authorize AWC and/or staff involved with my care to discuss medical/or billing information with the following persons.

Name _____Relationship _____

I authorized the release of any information concerning my (or my child's) healthcare, to expedite insurance payment. I also authorize payment of insurance and understand that I am responsible for all charges, regardless of insurance coverage.

_____ _____

Signature of patient, parent, or legal guardian Date

EMAIL ADDRESS_____

PATIENT CANCELLATION/NO-SHOW POLICY

ALTAMONTE WOMEN'S CENTER, P.A.
ANN A. ASHLEY-GILBERT, M.D. BILLIE JEAN PACE, M.D.

I understand that the AWC has a cancellation/no show policy, and that I will be charged for any appointments I cancel or miss with less than a 24 hour notice. Cancellations are reserved for emergencies only and require the minimum 24 hour notice. If you arrive more than 15 minutes after your scheduled time without notification that will be considered a no-show/cancellation. I understand that I must call if I am going to arrive later than 15 minutes of my scheduled time.

We schedule your time specifically for you and there will be a $50.00 cancel/no show fee for any appointments that have less than a 24 hour notice. Cancellation fees are due before or at rescheduled appointment.

By signing below, I understand the above policy.

Patient Name_____

Patient Signature_____

Date_____