Associates in Women's Health

Matthew A. Roberts, D.O. • Terry L. Williams Jr., D.O. • Mary Helen Durland, FNP • Tessa Eckhardt, FNP • Heidi Septor, FNP • Hannah White, FNP

PATIENT INFORMATION

Date: _____

Name: _____

(Last) (First) (MI)

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ Marital Status: _____

SS#: _____ Birthdate: _____

E-mail address: _____

Employer: _____

Address: _____

Spouse Name: _____

SS#: _____ Birthdate: _____

Employer: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Name: _____

Subscriber Name: _____DOB:_____Relationship:_____

Secondary Insurance Name: _____

Subscriber Name: _____DOB:_____Relationship:_____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: ( )_____ Cell Phone:( )_____

Who referred you to our office? _____

Preferred Pharmacy & Location: _____

Associates in Women's Health

Matthew A. Roberts, D.O. • Terry L. Williams Jr., D.O. • Mary Helen Durland, FNP • Tessa Eckhardt, FNP • Heidi Septor, FNP • Hannah White, FNP

Patient Authorization & Consent

Patient Name: _____
(Please Print)

- I consent to treatment necessary for the care of the above named patient.
- I authorize the release of all of my medical records to the referring and family physicians and to my insurance company, if applicable.
- I acknowledge full financial responsibility for services rendered by Matthew A. Roberts, D.O. or Terry L. Williams Jr., D.O. on the date of service.
- I agree to pay all reasonable attorney fees, court cost, and collection costs in the event of default of payment of my charge.
- I further authorize and request that insurance payment be made directly to Matthew A. Roberts, D.O, or Terry L. Williams Jr., D.O. should he receive such payment. It is my responsibility to obtain any referrals from my primary care physician required by insurance company.
- All fees are subject to change without notification.
- We will request a deposit toward your unmet deductible when scheduling a procedure and this payment is due one week prior to your appointment or surgery.
- Office visit copayments and patient portions are due at the time of service.
- Under the 1996 Health Insurance Portability Accountability Act (HIPAA) patient is responsible for their copayments, deductibles and balances not covered by the insurance and we do not extend courtesy or professional discounts for these balances as this is in violation of these regulations.
- Monthly statements are sent to patient at the first of each month for balance due. All balances are due in full within 10 days of receipt of statement. If payment cannot be made in full when due, you must contact our patient account department at (423) 899-8809 to set up extended payment plan.
- Delinquent accounts with no payment arrangements may be referred to our collections agency. A service charge will be added to the balance when the account is referred to outside collections. After a final notice is sent to the patient, they will have 10 days to settle the outstanding balance before the account is turned.
- The providers at Associates in Women's Health reserve the right to perform random drug screens at any time at his/her discretion.

I have read and have full understanding of the Associates in Women's Health Financial Policy, Consent for Treatment, Release of Medical Information, and Insurance Authorization.

Date: _____ **Signature:**_____