



Amy Garcia, MD

PATIENT INFORMATION

Name: (First) (Middle) (Last)

Single Married Partnered Widowed Separated Divorced

Address:

City: State: County: Zip Code:

Home Phone: Work Phone: Cell Phone:

Birth Date: Social Security Number:

Email address optional:

Can we send statements to you by email? Yes No

Do you want to receive quarterly Center for Women's Surgery Newsletter by email? Yes No

Patient Employer: Occupation:

Business Address:

Emergency Contact Name: Phone:

Relationship:

Who is your Primary Doctor? Referred by:

PRIMARY HEALTH INSURANCE

Insurance Company Name:

Insured Person: Birth Date: Social Security:

Policy Number: Group Number:

SECONDARY HEALTH INSURANCE

Is Patient covered by additional insurance? Yes No

Insurance Company Name:

Insured Person: Birth Date: Social Security:

Policy Number: Group Number:

FINANCIAL POLICY

CREDIT POLICY It is our policy that all deductibles, co-pays, or percentages of fees must be paid at the time service is provided. Accounts will be considered delinquent 30 days after notice of account balance due. Delinquent accounts will accrue interest at a rate of 10% per annum.

AGREEMENT OF FINANCIAL RESPONSIBILITY I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay any collection and/or attorney's fees should I fail to pay for all charges for which I am responsible. I understand I will be billed for missed appointments if I fail to give at least 24 hours notice of cancellation.

ASSIGNMENT AND RELEASE I hereby authorize and assign directly to Dr. Amy Garcia and Center for Women's Surgery all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand this is an ongoing release of records.

Responsible Party Signature

Relationship (if other than self)

Date