NORTHLAND WOMEN'S HEALTH CARE, P.C.
OBSTETRICS / GYNECOLOGY

PATIENT DEMOGRAPHIC INFORMATION AND FINANCIAL RELEASE

First Name _____ MI ____ Last Name _____ Account No. _____

Preferred Name (if different) _____ Date of Birth _____

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed

Street Address _____ Apt. _____ City _____ State ____ Zip _____

Address Type – ○ Home ○ Relative ○ Other _____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred Contact Phone ○ Home Phone ○ Cell Phone ○ Work Phone

Email Address _____ Social Security No. _____

Language ○ English ○ Spanish ○ Other _____ **Race** ○ American Indian/Alaska Native ○ Asian

○ Black or African-American ○ Native Hawaiian ○ White ○ Refused to report/unreported

Ethnicity ○ Hispanic or Latino ○ Non-Hispanic or Latino ○ Refused to report/unreported

Employed by _____ How did you hear about us? _____

INSURANCE INFORMATION

Do you have healthcare insurance? ○ Yes ○ No Primary Insurance Company _____

ID No. _____ Group No. _____

Subscriber Name _____ Date of Birth _____ Social Security No. _____

Relationship to Patient _____ Employer Name _____

Do you have secondary insurance? ○ Yes ○ No Secondary Insurance Company _____

ID No. _____ Group No. _____

Subscriber Name _____ Date of Birth _____ Social Security No. _____

Relationship to Patient _____ Employer Name _____

Name _____ Phone _____ Relationship _____

I hereby authorize the release of any medical and billing information necessary to process payment for claims and request benefits to be mailed directly to the physician until I revoke said authorization in writing. I understand that I (and spouse if married, or parent if minor) assume responsibility for payments of amounts due for services rendered and above the amount covered by insurance or the total amount, if I do not have applicable insurance coverage. My signature below guarantees my assumption of responsibility to the amount owed pursuant to this agreement.

Patient Signature

Date _____

_____

Signature

Please continue on next page

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AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION – COMPOUND RELEASE

Northland Women's Health Care, P.C. is authorized to release protected health information about the below named patient in the following manner and to identified persons.

First Name _____ MI ____ Last Name _____

Date of Birth _____ Account No. _____

Preferred Contact Phone _____ May we leave a voice mail that includes sensitive information? ○ Yes ○ No

May we discuss your information with others such as a Spouse or Parent? ○ Yes ○ No

NAME	RELATIONSHIP	PHONE	
_____	_____	_____	☐ Financial ☐ Medical
_____	_____	_____	☐ Financial ☐ Medical
_____	_____	_____	☐ Financial ☐ Medical

May we send you information via text message?* ○ Yes ○ No When I mark YES, **I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately, and I still elect to receive text communications.**
If yes, please select applicable box(es) ☐ Appointment Reminder ☐ Other _____

May we send you information via email?* ○ Yes ○ No When I mark YES, **I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately, and I still elect to receive email communications.**
If yes, please enter email address _____ and select applicable box(es) below
☐ Financial ☐ Medical ☐ Appointment Reminder ☐ Breach Notification

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient in writing.

Patient Signature

Date _____

_____
Signature

*Description of Personal Representative's Authority _____