Women's Cancer Care Associates LLC Demographics

Patient Information

Name: _____ Date of Birth: ___/____/____ Age: _____

Address: _____ City: _____

State: _____ Zip: _____ Social Security Number: _____ - _____ - _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Race: _____ Ethnicity (circle): Hispanic/Spanish Non Hispanic/Spanish

Primary Language: _____

Primary Physician: _____ Telephone #: (_____)_____

Pharmacy: _____ Location: _____ Phone#: _____

Insurance Information

Primary Insurance Co.: _____ ID#: _____

**If you are not the primary insurance holder, please provide the following information:*

Insured's Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Co.: _____ ID#: _____

**If you are not the primary insurance holder, please provide the following information:*

Insured's Name: _____ DOB: _____ Relationship: _____

Patient Authorization

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance, and third party payers to WOMEN'S CANCER CARE ASSOCIATES LLC. In the event that my insurance carrier does not accept assignment of benefits, or if payments are made directly to me, I will endorse said payments to WOMEN'S CANCER CARE ASSOCIATES LLC. I hereby authorize said assignee to release all information, including claim forms and medical records, necessary to secure payment.

FINANCIAL RESPONSIBILITY STATEMENT

All copayments must be paid at the time of service. In the event that my insurance carrier fails to remit payment due to lack of information on my part, I will be responsible for the monies owed. In the event that I fail to notify WCCA in a timely fashion of a change in my insurance, I will be responsible for the monies owed. I understand that I am responsible for services not covered under my insurance contract, such as routine care or cosmetic procedures.

I HAVE READ THE ABOVE STATEMENTS AND ACCEPT THE TERMS. A COPY WILL BE MADE AVAILABLE TO ME UPON REQUEST.

_____ _____

Patient Signature **Date**

_____ _____ _____

Responsible Party **Relationship** **Date**

************THIS AGREEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING************