Women's Cancer Care Associates LLC **Demographics**

Patient Information

Legal Name: ____ Date of Birth: ___/____/____ Age: ______

Preferred Nickname: _______________________ Gender Identity: __________ Preferred Pronouns:_____________

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************