



**Kim B. Rashada, MS, MD, FACOG**

**PATIENT INFORMATION FORM**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Marital Status:  Single  Married  Separated  Divorced  Widowed  
Spouse/Partner's Name: \_\_\_\_\_ Spouse/Partner's Date of Birth: \_\_\_\_\_  
Spouse/Partner's Employer: \_\_\_\_\_ Spouse/Partner's Work Phone#: \_\_\_\_\_  
Spouse SS#: \_\_\_\_\_ Referred by: \_\_\_\_\_

**INSURANCE INFORMATION:**

Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Other Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

**GENERAL INFORMATION:**

Name of Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

I have completed this form and certify that I am the patient or duly authorized agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment and that payment is due on the date service is received. I authorize the release of my medical history, information, or records concerning my diagnosis and treatment by WOMEN'S CARE FIRST, P.A. I may be required to substantiate or explain insurance claims filed, and I authorize payment directly to WOMEN'S CARE FIRST, P.A. and permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing. If I have Medicare coverage, I request the payment of authorized Medicare benefits be made to me or on my behalf to WOMEN'S CARE FIRST, P.A. for any services furnished me by that physician or supplier. I authorize any holder of information about me to release to the Health Care Financing Administration and as agent any information needed to determine those benefits payable for related services.

**FINANCIAL AGREEMENT**

1. In the event WOMEN'S CARE FIRST, P.A. shall find it necessary to refer this matter to a collection agency or other party responsible for recovering payments due hereunder, all costs incurred with such collection including, but not limited to, attorney's fees and costs at all levels, shall be the responsibility of the patient, his or her authorized representative, guarantor or designee. In the event a court of competent jurisdiction finds against WOMEN'S CARE FIRST, P.A. for the collection of such payment, each party shall be responsible for his own fees and costs including attorney's fees at all levels.
2. I certify that I am the patient or am duly authorized by the patient as the patient's general agent to execute this document and accept its terms.
3. I understand, as a courtesy, Women's Care First, P.A. shall file my insurance.
4. I understand a \$25.00 fee may be assessed if I do not give at least a 24 hour notice for cancelling/missing an appointment.

Signature of Patient or Authorized Person: \_\_\_\_\_ DATE: \_\_\_\_\_

Witness: \_\_\_\_\_ DATE: \_\_\_\_\_