EAST CASCADE
WOMEN'S GROUP

PARTNER INFORMATION

First Name	Middle Initial	Last Name	Age	Date of Birth

Mailing Address	City	State	Zip

Phone number	Marital Status M S W D P	Primary Care Provider Name

May we leave medical and accounting info on voicemail? ☐ Yes ☐ No	Email address

PARTNER INFORMATION

Name of spouse or partner	Partner's Date of birth	Partner's phone number

Permission to speak with your partner about lab results: ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance company	Name of subscriber	Subscriber member ID	Group #

Credit Policy and Insurance Authorization

We bill all insurance as a courtesy when you provide us with your current information. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. We do not have any control over your insurance companies' interpretation of their responsibility to pay your bill or when. Our agreement is with you, the patient. We accept Visa, MasterCard and Discover. We request payment at time of service if you are uninsured.

I hereby authorize East Cascade Women's Group to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to said doctors all monies to which they are entitled for medical and/or surgical expense relative to the services performed from time to time, but not to exceed my indebtedness to said physician and surgeons. I understand I am financially responsible to said doctors for all charges for services received.

Signature Date

Acknowledgement

I acknowledge that I have received the Notice of Privacy Practices from East Cascade Women's Group.

Signature Date