Timothy L. Sandmann, MD

Helen A. Watson, WHNP

WOMEN'S CARE & CONTINENCE CENTER

Patient Information Form

Last Name_____First Name_____MI___ DOB:_____/_____/_____
SSN:_____-____-_____ Cell phone: (____)____-_____ Home phone: (____)____-_____ Preferred: Cell Home
Street Address:_____ City:_____ State_____ Zip:_____
Email:_____ Employer:_____ Work phone: (____)____-_____
Referred by:_____ Emergency Contact:_____
Emergency Contact phone: (____)____-_____ Relationship:_____
Pharmacy Name:_____ Pharmacy Phone: (____)____-_____
If a mail-in pharmacy, please list a physical pharmacy for acute medications:_____
If a chain pharmacy, list cross streets:_____&_____

Insurance Information

Insurance Company – Primary:	Insurance Company – Secondary:
Policy Holder: __Self __Other – Name:	Policy Holder: __Self __Other – Name:
Policy Holder DOB_____/_____/_____	Policy Holder DOB_____/_____/_____
Policy/Member ID#:_____	Policy/Member ID#:_____
Group #:_____	Group #:_____

Release of Information and Insurance Assignment

I hereby authorize payment directly to the above mentioned physician(s) of any surgical and/or medical benefits, otherwise payable by me for the services as described on attached claim.

I also hereby authorize above named physician(s) to release information (including records of HIV-testing or sexually transmitted disease) to my health and/or accident insurance company which may be requested regarding my present illness or injury.

I request that payment of authorized Medicare benefits (and/or other insurance) be made either to me or on my behalf to the physicians listed on this form for any services furnished to me by those physicians. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits for related services.

I understand that I am responsible for payment of the patient portion of my bill within 30 days of payment by my network insurance. If I do not have network insurance, I am responsible for payment at time of service.

We accept American Express, Mastercard, Visa, personal check and cash for payment.

HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. This form is available in our lobby for review or a copy can be provided upon your request. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (903) 870-1080 or (972) 542-5444.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices and understand the release of information and insurance assignment.

Print Name: _____ Signature:_____ Date: _____/_____/_____