WEST VALLEY WOMEN'S CARE

NEW PATIENT REFERRAL FORM

NAME: ____ **DATE:** ____________________

Please Select Only one:

HOW DID YOU HEAR ABOUT US?

- **REFERRING DOCTOR:** ____
  NAMES: ____

  PHONE NUMBER: ____

  FAX #____

  ADDRESS: ____
- **FAMILY OR FRIEND:** ____
- **WEST VALLEY VIEW:** ____

CHART #: ____________________ West Valley Women's Care, Ltd. PROVIDER: ____________________

PATIENT INFORMATION

PATIENT NAME: ____
LAST FIRST MIDDLE

ADDRESS: ____

ZIP CODE: ____________________ CITY: ______________________________ STATE: __________

HOME PHONE #: (______) ______-_______ **CELL PHONE #:** (______) ______-_______ EMAIL ADDRESS: ____________________

DATE OF BIRTH: ________/________/________ **SOCIAL SECURITY NUMBER:** ________-________-________

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT'S EMPLOYER INFORMATION: COMPANY: ______________________________

CITY: ______________________________ PHONE #: ______________________________

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME: ____
LAST FIRST MIDDLE

ADDRESS: ____

DATE OF BIRTH: ________/________/________ **SEX:** (circle one) FEMALE MALE

HOME PHONE #: (______) ________-______________ **WORK PHONE #:** (______) ________-______________

SOCIAL SECURITY NUMBER: __________ - __________ - ______________

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: COMPANY: ______________________________
CITY: ______________________________ PHONE #: ______________________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:
____

ADDRESS: ____ PHONE: ____________________

CONTRACT (ID#) NUMBER: ____________________ **SUBSCRIBER'S NAME:** ______________________________

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: ______________________________ GROUP NUMBER: ______________________________

COPAYMENT AMOUNT: $ ____________________ INSURED'S DATE OF BIRTH: ________/________/________

SECONDARY INSURANCE
COMPANY:____

ADDRESS: ____ PHONE: ____________________

CONTRACT (ID#) NUMBER: ____________________ **SUBSCRIBER'S NAME:** ______________________________

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: ______________________________ GROUP NUMBER: ______________________________

COPAYMENT AMOUNT: $ ____________________ NSURED'S DATE OF BIRTH: ________/________/________

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.
WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 35% of said unpaid balance, including a reasonable attorneys fee.

NO SHOW POLICY:

Effective October 1st, 2010, a no show fee of $25.00 will be billed to all patients who no show to their scheduled appointment.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. ***You are responsible for all deductibles and charges not covered by insurance.*** *Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.*

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

We contact your insurance to verify coverage benefits on procedures as a courtesy but this is not always a guarantee of your insurance paying.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

SIGNED: ____ **DATE:** ____________________

Patient, Parent, or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: ____

PHONE NUMBER: ______________________ RELATIONSHIP: ___________________________

ADDRESS: ____

PERSONAL MEDICAL RELEASE:

I ______________________, (PRINT) hereby authorized West Valley Women's Care to release all personal medical information to the following person(s):

Name	Relationship	Phone#
Name	Relationship	Phone #
Name	Relationship	Phone#

☐ I do not authorize anyone to obtain my medical records.

YES	No	
X ☐	X ☐	May we leave a messages regarding personal medical information on your voice mail

West Valley Women's Care

Authorization To Release Records

Patient Name: ______________________ SSN# ______________________

Address: ______________________

Date Of Birth: ____________ Phone: (Day) ____________ (Home) ____________

I hereby authorize release of medical records to:
West Valley Women's Care, Ltd
9305 w Thomas Rd # 155
Phoenix, AZ 85037
Phone: (623)936-1780
Fax: (623) 936-9116

Self: ______________________

Physician: ______________________ Specialty: ______________________

Address: ______________________

Phone: ______________________ Fax: ______________________

For the purposes hereof, "Medical Records" and "Radiological Films" shall include all confidential HIV-related information (as defined in A.R.S. Section 36-661), confidential communicable disease-related information (as defined in A.R.S. section 36-661), confidential alcohol or drug abuse-related information (as defined in 42 CFR section 2.1 ET SEQ), and confidential mental health diagnosis/treatment information.

Medical Records

- ☐ All medical records of the past two(2) years of treatment, and/or,
- ☐ Most recent Pap smear, and/or,
- ☐ Operative report dated:_______, and/or,
- ☐ Other Records:________________________________

This consent will expire sixty (60) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization providing I make my notification in writing to that effect. I understand that any release, which was made prior to my revocation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. I understand that a photocopy or facsimile of this authorization is considered acceptable in lieu of the original.

Patient Signature ______________________ Date: ____________

Parent/Guardian: ______________________ Date: ____________