RHETT WOMEN'S CENTER

725 Longpoint Road, Mt. Pleasant, SC 29464
(843) 375-2210

Rhett Women's Center

PATIENT INFORMATION

PLEASE PRINT CLEARLY
Full Name

_____

Street Address _____City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Employer/School _____

Occupation

_____

Employer Address _____

Home Phone # _____Work Phone # _____ Cell Phone #_____

Date of Birth _____ SS# _____

Spouse's Full Name _____Spouse's Employer_____

Employer's Address _____

Work Phone # _____Spouses's SS# _____ Date of Birth _____

Nearest Relative Not Living with you _____ Phone # _____

INSURANCE INFORMATION

*IN THE EVENT OF HOSPITALIZATION OR MAJOR PROCEDURES, WE REQUEST YOUR INSURANCE INFORMATION FOR OUR RECORDS.

Do you have medical insurance? □Y □N Referred by _____

PRIMARY INSURANCE TO FILE

Policy # _____ Group # _____

Insured's Name _____ Relationship to Patient _____

Insured's Social Security # _____ or ID # _____

Insurance Co. Name _____ Insurance Co. Phone # _____

Insurance Co. Address _____

SECONDARY INSURANCE TO FILE

Policy # _____ Group # _____

Insured's Name _____ Relationship to Patient _____

Insured's Social Security # _____ or ID # _____

Insurance Co. Name _____ Insurance Co. Phone # _____

Insurance Co. Address _____

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize this authorization allows Rhett's Women's Center to release any information to any of my insurers or physicians as requested by such insurer or physician.

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE, GROUP POLICY BENEFITS AND OTHER HEALTH PLANS TO RHETTS WOMEN'S CENTER. RHETT'S WOMEN'S CENTER DOES NOT EXTEND CREDIT. I HEREBY AGREE TO PAY ALL COSTS AND REASONABLE ATTORNEY FEES IN THE EVENT THIS ACCOUNT IS TURNED OVER TO AN ATTORNEY AT LAW FOR COLLECTION.

I understand that I am financially responsible to Rhett's Women's Center for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or have an agreeable payment arrangement set up with the business office.

_____ Date _____
Responsible Party Signature

_____ Date_____
Responsible Party Signature

_____ Date_____
Responsible Party Signature